The Brook Hill School
Christ-Centered. College Prep.

The Brook Hill School Immunization Requirements

Student Name: _____

Date of birth: ____ /____ /_____ Male Female (circle one)

Take this form to student's physician to be completed and signed by student's physician.

- Any lacking immunizations will be the financial responsibility of the student or parent upon arrival to Brook Hill
- Only this form will be accepted for immunization verification
- Form will not be accepted without a physician signature

Physician: Please complete dates of following vaccines, please write dates clearly and legibly.

Tetanus/Diphtheria/Pertussis 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

5 or 10 year booster _____

Polio 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Measles, Mumps, Rubella (MMR) 1. _____ 2. _____

Hepatitis B 1. _____ 2. _____ 3. _____

Varicella 1. _____ 2. _____

Meningococcal 1. _____ 2. _____ (2nd dose only required for Seniors)

Hepatitis A 1. _____ 2. _____

_____ _____

Physician Signature Printed Name of Physician

(____) _____-_____ _____

Phone Number Address, City, Country