Return completed form to:
Sharon Bergsholm RN
School Nurse
850 Maple Street
Glenwood City, WI 54013
Fax: 715-265-4214

GLENWOOD CITY SCHOOL DISTRICT
Student Immunization Record

Student: _____ M F Birthdate: _____

Parent(s): _____ Phone: _____

Complete Address: _____

List the month, day and year your child received each of the following immunizations.
You must use dates. Include any doses given today or attach a printout of vaccinations.

Tdap					
Polio (IPV)					
Hepatitis B					
MMR					
Chickenpox (Varicella)					
Other (List vaccine name & date)					

(if applicable) □ My child had the Chickenpox disease. (Date) _____

_____ _____
Parent Signature **Date**