

Date _____

Parent / Physician's Signature _____

Varicella (chickenpox) illness on or about _____ and does not need the vaccine.
This is to verify the person for whom this card was issued had:

PARENT/PHYSICIAN'S VERIFICATION OF VARICELLA (CHICKENPOX) ILLNESS

Parents Name: _____

School: _____

City, State, Zip Code: _____

Street Address: _____

Date of Birth: _____ Telephone No.: _____

Name: _____ Sex: M F

School / Child-care Immunization Record



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Stock No. C-11

Revised 07/2017

Texas Department of State Health Services
Immunization Unit

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA privacy notice.

DATE: _____		SIGNATURE: _____	
R20/	I20/	Pass	Fail
VISION			
H ₂	1000	2000	4000
R			
L			
		<input type="checkbox"/>	Pass
		<input type="checkbox"/>	Fail
DATE: _____		SIGNATURE: _____	
HEARING @ 25 dB			

Name: _____ Date of Birth: _____

VACCINES	DATE	DATE	DATE	DATE	DATE
Hepatitis B					
DTP/DTaP/DT					
Tdap					
Td					
OPV, IPV					
Hib					
Pneumococcal					
Rotavirus					
HPV					
MMR					
Hepatitis A					
Varicella					
MenACWY					
MenB					
Influenza					
Influenza					
Other					
Other					
Other					
TB Test _____ Date: _____ Result: _____					

Date: _____ Staff Signature: _____

Record hearing and vision on reverse.