Student _____ Date _____

Dear Parent/Guardian

Ohio Department of Health immunization requirements for school attendance are outlined on the reverse side of this form. Your child's immunization record has been reviewed and is incomplete for the following reasons:

____ Immunization(s) are needed as indicated below
____ No record is on file
____ Immunization dates are incomplete. Day, Month & Year required
____ Copy of Immunization record is not legible
____ Other _____

Please contact your doctor or clinic to obtain the required immunization(s). Written documentation of immunizations **must** be on file in the school office by _____.
Failure to provide the records may result in a change of services or your child's exclusion from school.
Thank you for your prompt response. Please call the school nurse with any questions or assistance.

_____
School Nurse

Immunizations and Dates:

Type	1st dose	2nd dose	3rd dose	4th dose	5th dose	6th dose
DTaP/DTP/Td						
Polio (Specify OPV or IPV)						
MMR (Measles, Mumps, Rubella)						
Hepatitis B						
Varicella (Chickenpox)						
Hib (preschool)						

Licensed Medical Provider signature (**required**) _____Date _____

Licensed Medical Provider printed name _____

Licensed Medical Provider address and telephone number _____

_____