



International Education
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Sudbury ON P3C 5E7
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sudburycatholicsschools.ca

IMMUNIZATION RECORD

Please enter date of administration in appropriate area. Where not administered, please mark "N.A."

Family Name

Given Name(s)

Day/Month/Year

	PRIMARY			BOOSTER	
	1st	2nd	3rd	4th	5th
DIPHTHERIA					
PERTUSSIS (WHOOPING COUGH)					
TETANUS					
POLIO					
MUMPS					
MEASLES					
RUBELLA (GERMAN MEASLES)					
HAEMOPHILUS INFLUENZA B					
B.C.G.					
VARICELLA					
MENINGOCOCCAL DISEASE					
HEPATITIS B					
OTHER					

I hereby certify that this is a true record of the immunizations received by the above-named.

Signature of qualified health professional

Day / Month / Year

Name: _____

Address: _____

Professional Designation: _____

Please attach a copy of the Immunization Record.