HUMAN PAPILLOMAVIRUS (HPV)	2			
	3			
MENINGOCOCCAL (meningitis)	1		☐ MCV ☐ MPV	
			☐ MCV ☐ MPV	

DT/Td = diphtheria, tetanus *(difteria, tétano)*
DTaP/Tdap = diphtheria, tetanus, and pertussis (whooping cough) *(difteria, tétano, y tos ferina)*
HIB = Hib meningitis *(Haemophilus influenzae type b) (meningitis Hib)*
HPV = human papillomavirus *(virus del papiloma humano)*
IPV = inactivated polio vaccine *(vacuna antipoliomielítica inactivada)*
LAIV = nasal spray influenza vaccine *(vacuna intranasal viva contra la influenza)*
MCV = meningococcal conjugate vaccine *(vacuna meningocócica conjugada)*
MMR = measles, mumps, rubella *(sarampión, paperas y rubéola (sarampión alemán))*
MPV = meningococcal polysaccharide vaccine *(vacuna meningocócica polisacárida)*
OPV = oral polio vaccine *(vacuna oral contra la polio)*
PCV = pneumococcal conjugate vaccine *(vacuna neumocócica conjugada)*
PPV = pneumococcal polysaccharide vaccine *(vacuna polisacárida contra el neumecoco)*
RV = rotavirus *(rotavirus)*
TIV = flu shot *(vacuna desactivada contra la influenza)*

TB SKIN TESTS* *Pruebas de la Tuberculosis*

Type**	Date given	Given by	Date read	Read by	mm indur	Interpretation
☑ PPD-Mantoux ☐ Other____	5/6/14	EAC	5/8/14	EAC	0	☐ Pos ☑ Neg
☐ PPD-Mantoux ☐ Other____	/ /		/ /			☐ Pos ☐ Neg
☐ PPD-Mantoux ☐ Other____	/ /		/ /			☐ Pos ☐ Neg

* A chest x-ray may be indicated if skin test is positive.
** If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY *(Radiografía)* (Necessary if skin test positive.)

Film date: ____/____/____ Interpretation: ☐ normal ☐ abnormal
Person is free of communicable tuberculosis: ☐ yes ☐ no
Signature/Agency: _____

Parents: Your child must meet California's immunization requirements to be enrolled in school and child care. Keep this Record as proof of immunization.

Padres: *Su niño debe cumplir con los requisitos de vacunas para asistir a la escuela y a la guardería. Mantenga este Comprobante: lo necesitará.*

IMMUNIZATION RECORD

Comprobante de Inmunización

EAST MONT WELLNESS CENTER
6955 FOOTHILL BLVD.
OAKLAND,CA 94605
(510)567-5700

Name *nombre* _____

Birthdate *fecha de nacimiento* _____

Allergies *alergias* _____

Vaccine Reactions *reacciones a cualquier vacuna* _____

ENC:20001679149 ADM: 05/08/2014
MR#: 10639236 61Y / Female
PEARSON, PAMELA
DOB: 04/01/1953 SVC: ADM

RETAIN THIS DOCUMENT — *CONSERVE ESTE DOCUMENTO*