Fax Cover Sheet
Fax: 361.825.5887

Student Information:

________________________________________
_________________________

First Name MI Last Name

Student ID: ____________________________

Date of Immunization: _________/_______/_________

PLEASE ATTACH ANY OF THE FOLLOWING:

• A document bearing the signature or stamp of the physician or his/her designee, or public health personnel (must include month, day, and year the vaccination was administered)

• An official immunization record generated from a state or local health authority (must include month, day, and year the vaccination was administered)

• An official record received from school officials, including a record from another state (must include the month, day, and year the vaccination was administered)

• An affidavit declining vaccination