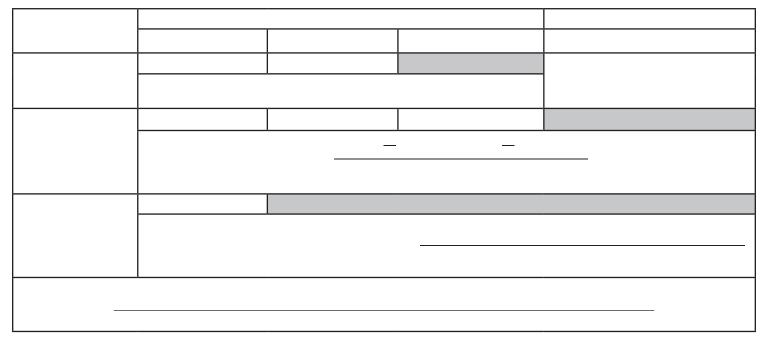
_ _____ _____

Mandatory Immunization/TB Screening Form

PATIENT NAMEirst and Last Student ID#:	DOBMonth/Day/Year AGE	:

TELEPHONE#:



				<u> </u>	