SAN GABRIEL/POMONA
REGIONAL CENTER

IMMUNIZATIONS AND TESTS

CLIENT NAME:	D.O.B.

THIS SECTION TO BE FILLED OUT BY SC

❑ **No inoculation records available prior to : _____ *(date)***

Service Coordinator Signature: _____ Date: _____

		DATE OF EACH IMMUNIZATION			
MUMPS					
MEASLES					
RUBELLA					
CHICKEN POX					
POLIO (TYPE)					
DPT					
HEP B SERIES					
DT					

DATE, REACTION OR RESULTS				
TUBERCULIN				
CHEST X-RAY				
OTHER, SPECIFY				

COMMENTS:

CONFIDENTIAL CLIENT INFORMATION
SAN GABRIEL/POMONA VALLEYS
DEVELOPMENTAL SERVICES, INC.
See California Welfare &
Institutions Code, Section 4514