Polio Vaccination Attestation

Student Name: _____ Student Number: _____

As the student's primary health care provider, I _____
Please Print Name

Attest that this student has received a full Polio Vaccination Serries, but records are not available and (choose one from the list below).

☐ No further vaccinations are required

☐ Booster given on _____ (dd/mm/yyyy), no further vaccinations required

☐ Patient will begin full adult series, first dose given on _____ (dd/mm/yyyy)

_____ _____
Physician/Nurse Practitioner Signature & Designation Date