'Iolani School
IMMUNIZATION RECORD

In lieu of filling in immunization dates below you may attach the physicians immunization summary generated by your electronic medical record.

***REQUIRED (FORM MUST BE COMPLETED IN ITS ENTIRETY WITH PHYSICIANS SIGNATURE IN ORDER TO BE VALID)**

***STUDENT NAME** _____
LAST NAME FIRST NAME MI

***DATE OF BIRTH** _____
MM/DD/YYYY

TYPE OF VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
Name of Vaccine					
Tetanus, Diphtheria, Pertussis	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
DTP,DtaP,DT,Td,Tdap	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
Polio (IPV, OPV)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
MMR (combo)	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Measles	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Mumps	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Rubella	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
Hepatitis B	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
Hepatitis A	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
Meningococcal	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
HPV	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Name of Vaccine					
Varicella	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Immunity Secondary to Illness	**Date of Illness:** _____		**Practitioner's Signature:** _____		

PHYSICIAN: I hereby certify that the above information and/or attached documentation of the student named above has been reviewed by me and is accurate to the best of my knowledge.

*Signature of U.S. Licensed Practitioner (MD,DO,PA,APRN)
SIGNATURE REQUIRED

*Date Signed Printed/Stamped Name and Phone Number

IMMUNIZATION REQUIREMENTS FOR ALL ʻIOLANI STUDENTS

Vaccine	Number of Doses	Minimum Time Interval
Diphtheria, Tetanus, Pertussis (DTaP or DTP)	5 doses	1st dose: Not given before age 6 weeks 2nd dose: 4 weeks after 1st dose 3rd dose: 4 weeks after 2nd dose 4th dose: 6 months after 3rd dose AND not before age 12 months 5th dose: 6 months after 4th dose AND not before age 4 years
Tdap **<Required for all 7th graders and newly enrolled Upper School students>**	1 dose	1 dose: Not before age 10 years
Polio (IPV, OPV or combination)	4 doses	1st dose: Not before age 6 weeks 2nd dose: 4 weeks after 1st dose 3rd dose: 4 weeks after 2nd dose 4th dose: 6 months after previous dose AND not before age 4 years
Measles, Mumps, Rubella (MMR)	2 doses	1st dose: Not before age 12 months 2nd dose: 4 weeks after 1st dose *****At least 1 of the 2 doses must be the MMR combination*****
Hepatitis A (Hep A) ***<Required for Kindergarten and all newly enrolled students>***	2 doses	1st dose: Not before age 12 months 2nd dose: 6 months after 1st dose
Hepatitis B (Hep B)	3 doses	1st dose: Birth 2nd dose: 4 weeks after 1st dose 3rd dose: 8 weeks after 2nd dose AND 16 weeks after 1st dose AND not before age 24 weeks
Varicella (Chicken Pox)	2 doses	1st dose: Not before age 12 months 2nd dose: 12 weeks after 1st dose (for students aged 12 months to 12 years OR 4 weeks after 1st dose (for students aged 13 years and older)
Meningococcal (MCV) **<Required for all 7th graders and newly enrolled Upper School students>**	1 dose	1 dose: Not before age 10 years
Human Papillomavirus (HPV) **<Required for all 7th graders and newly enrolled Upper School students>**	2 doses	1st dose: Not before age 9 years 2nd dose: 5 months after 1st dose **Students aged 15 years or older at initial vaccination, require 3 doses; 1st dose not before age 9 years, 2nd dose minimum 4 weeks after 1st dose, 3rd dose minimum 12 weeks after 2nd dose AND 5 months after 1st dose

Note: The immunizations listed above are required for school attendance in accordance with Hawaiʻi State Department of Health requirements.

Revised 10/21/2026