



# MT. VERNON

COMMUNITY SCHOOL CORPORATION

*Engage, Educate & Empower Today's Students*

Tracy Furnas, RN, MVCSC Corporation Nurse

Phone: (317)-485-3100 Fax: (317)-482-4113

Email: [tracy.furnas@mvcsc.k12.in.us](mailto:tracy.furnas@mvcsc.k12.in.us)

## Alternate Schedule For School Required Immunizations

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Vaccination	Scheduled Date of Dose 1	Scheduled Date of Dose 2	Scheduled Date of Dose 3	Scheduled Date of Dose 4	Scheduled Date of Dose 5
Hep B					
DTaP					
Polio					
Varicella					
MMR					
Hep A					
MCV4					
Tdap					

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge. I also further understand that the scheduling facility listed below is not responsible if a scheduled dose is missed/rescheduled or for providing the school record of any received vaccination(s).

\_\_\_\_\_  
Printed Name of Physician/Health Dept. Rep.

\_\_\_\_\_  
Name/Phone of Physician Office/Health Department

\_\_\_\_\_  
Signature of Physician/Health Dept. Rep.

\_\_\_\_\_  
Date