



VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053

To Be Completed by Panel Physician Only

Name (Last, First, MI.)			Exam Date (mm-dd-yyyy)	REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS NOT REQUIRED FOR REFUGEE APPLICANTS NOTE FOR PANEL PHYSICIANS: For refugee applicants, please complete only if reliable vaccination documents are available.
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number		

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)				Vaccine Given by Panel Physician (mm-dd-yyyy)	Completed Series (✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below					
	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)			Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall (Flu) Season	
Specify (check) vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP												
Specify (check) vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap												
Specify (check) vaccine: <input type="checkbox"/> Polio -OPV <input type="checkbox"/> IPV												
Specify (check) vaccine: <input type="checkbox"/> MMR (Measles-Mumps-Rubella) <input type="checkbox"/> Rubella												
Specify (check) vaccine: <input type="checkbox"/> Measles <input type="checkbox"/> Measles - Rubella												
Specify (check) vaccine: <input type="checkbox"/> Mumps <input type="checkbox"/> Mumps - Rubella												
Rotavirus												
Hib												
Hepatitis A												
Hepatitis B												
Meningococcal												
Human papillomavirus												
Varicella												
Zoster												
Pneumococcal												
Influenza												

2. Results

- Vaccine History Incomplete
- Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as Indicated Above).
- Applicant will request an individual waiver based on religious or moral convictions.
- Vaccine history complete for each vaccine, all requirements met (Documented Above).
- Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician (Name) _____

Panel Physician (Signature) _____

Date (mm-dd-yyyy) _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of burden and recommendations for reducing it to: Department of State (A/ISS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Section 212 (a) and 221 (d), and as required by INA Section 212(g)(2). If an immigrant visa is issued, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued, this form will be treated as confidential under INA Section 222(f).