THIS IS A REQUIRED FORM *Day Care Provider Name* ________________

Child Immunization Record

Child's Name ______________________________ **Date of Birth** ______________

Parent's Name ___________________________ **Phone** ____________________

Address ____
Street Address City State Zip

Record Date of Immunization

	1	2	3	4	5
Hep B					
DtaP / DTP / Td					
Hib					
MMR					
IPV					
Varicella					
PCV / Prevnar					

Child has documented history of Varicella Disease _____ No _____ Yes If yes, age _______

Please check the appropriate response.

- ☐ Child has received complete age-appropriate immunizations.
- ☐ Child is currently in the process of receiving complete age-appropriate immunizations.

ONE BOX ABOVE MUST BE CHECKED BY THE HEALTH CARE PROVIDER

Comments: ***(Please list immunizations excluded for medical reasons)***

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Parent comments: (Please indicate religious objection, if any)

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Signature______________________________ Date____________________
(Health Care Provider's Signature and Date is **Required**.)

Printed Name and Title ____
(Printed Name and Title is **Required**)

This form must be updated annually.