***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*

| | Birth | 1 mo | 2 mo | 4 mo | 6 mo | 12-18 mo | 2-3 yr | 4-6 yr |
|---|---|---|---|---|---|---|---|---|
| Hep B | | | | | | | | |
| DtaP / DTP / Td | | | | | | | | |
| Hib | | | | | | | | |
| MMR | | | | | | | | |
| IPV | | | | | | | | |
| Varicella | | | | | | | | |
| PCV / Prevnar | | | | | | | | |
| Hep A | | | | | | | | |

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)*** _____

_____

_____

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

_____

_____

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