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

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.