**IMMUNIZATION RECORD**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Immunization | Date  1st Dose | Date  2nd Dose | Date  3rd Dose | Date  4th Dose | Date  5th Dose |
| Polio (3 doses) |  |  |  |  |  |
| DTP/Td (4 doses) |  |  |  |  |  |
| Hib (3 doses)**\*\*\*** |  |  |  |  |  |
| MMR ( 1 dose)**^** |  |  |  |  |  |
| Varicella **\*** (1 dose)**^** |  |  |  |  |  |
| Hepatitis A (2 doses) |  |  |  |  |  |
| Hepatitis B (3 doses) |  |  |  |  |  |
| Pneumococcal ( 4 doses**)\*\*\*** |  |  |  |  |  |
|  |  |  |  |  |  |
| **\*** if your child has had chicken pox, please give the date |  |  |  |  |  |
| **^** Kindergarten students are required to have 2 doses |  |  |  |  |  |
| \*\*\*doses vary depending on date of first vaccine |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Signature (or stamp) Date Signature Date

Physician or Health Personnel Staff making handwritten copy of record

**NOTE:** You may submit an immunization record from your physician’s or health personnel if it has a stamp or signature of the doctor.



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| **HEALTH HISTORY**    **Child’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Significant Medical Events**: Circle Y or N, if “Yes” please explain.  Operations: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Injuries: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seizures: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospitalization: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food Allergies or Restrictions: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please list medications that are currently needed for allergy or asthma maintenance.)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Examination: CHECK those that ARE essentially NORMAL:**  \_\_\_Skeletal System \_\_\_Skin \_\_\_Teeth \_\_\_Eyes \_\_\_Height \_\_\_Scoliosis \_\_\_Heart \_\_\_Nose \_\_\_Weight \_\_\_Nervous System \_\_\_Lymph Nodes \_\_\_Throat  \_\_\_Ears \_\_\_Lungs \_\_\_Abdomen \_\_\_Tonsils  **Vision and Hearing Examination**: (for children ages 4 and over)  Left\_\_\_\_\_\_Right\_\_\_\_\_\_Vision Score\* Left\_\_\_\_\_\_Right\_\_\_\_\_Hearing Score\*  Left-Pass/Fail Right-Pass/Fail Left-Pass/Fail Right-Pass/Fail  \**Physicians: Vision and Hearing screenings must be completed for children ages 4 and over.*  **Limitations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Physical Education Restrictions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.    **Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_      Revised 2/7/19 |