**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 |