



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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 / Pevnar								
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 _____
 (HealthCare Provider's Signature and Date is **Required**.)

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

This form must be updated annually.