

**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.**