Date of Birth: Mo/Da /Yr Each Dose was Received

Type of Vaccine	1st Mo/Day/Yr	2nd Mo/Day/Yr	3rd Mo/Day/Yr	4th Mo/Day/Yr	5th Mo/Day/Yr
(DTP) Diphtheria, Tetanus & Pertussis	/ /	/ /	/ /	/ /	/ /
(DT) Diphtheria & Tetanus	/ /	/ /	/ /	/ /	/ /
(Td) Tetanus, Diphtheria	/ /	/ /	/ /	/ /	/ /
(OPV) Oral Polio	/ /	/ /	/ /	/ /	/ /
(IPV) Inactivated I					/
(MMR) Measles, M					/
(Hib) Haemophilu					
(Hib) Name of Manu					/
(Hep A) Hepatitis					/
(Hep B) Hepatitis					
TB Skin test (include result)					
(VAR) Varicella	/ /	/ /			
Other	/ /	/ /			
Other	/ /	/ /			

The Child Care Licensing Department now requires that each child's parent or guardian provide a copy of his/her shot records. Thank-You!

Signed Exemption to requirements is on file because of:
■ Medical or ■ Personal
■ Permanent ■ Temporary - Until _____

I certify the immunizations documented above have been verified through careful review of a record (or records) issued by the following health provider(s):

_____

PLEASE PRINT NAME(S) OF HEALTH CARE PROVIDER(S)

_____

NAME (PLEASE PRINT) AND SIGNATURE OF PERSON REVIEWING VERIFIED RECORD DATE

Notification of immunizations needed sent to Parent(s) or Guardian(s): ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR

C hild's Name:_____ Date of Enrollment:_____ Updated:_____

Street Address:_____ Date of Birth:_____ Sex: _____

City & State: _____ Zip Code: _____ Home Phone: _____

Mother or Guardian:
Name: _____
Home Address: _____ Hm. Ph:_____
Business Address: _____ Wk. Ph:_____
Signature: _____

Father or Guardian:
Name: _____
Home Address: _____ Hm. Ph:_____
Business Address: _____ Wk. Ph:_____
Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: Name_____ Address _____ Phone_____

HOSPITAL: Name _____ Address _____ Phone_____

In case of injury or sudden illness, _____ will be called. I hereby give authority to any hosp[ital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

Parent or Guardian: _____

Signature: _____

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____ Name: _____

Address: _____ Address: _____

Telephone : _____ Telephone : _____

Signature: _____ Signature: _____

Name: _____ Name: _____

Address: _____ Address: _____

Telephone : _____ Telephone : _____

Signature: _____ Signature: _____

I hereby permit the center to release my children to the above persons upon my telephone authorization.

Parent Signature: _____ Phone: _____

The following persons may not remove my child from the center:

Name: _____ Name: _____ Y___N___ Custody papres on file.

The above enrollment and emergency information was provided by:

Signature: _____ Date: _____

Medical Information

Is child allergic to food or other substances? (If so, name foods or substances to be avoided and procedure to follow if reaction occurs.)

Is child usually susceptible to infections and if so, what precautions need to be taken?

Is child subject to convulsions and what should be our procedure if one occurs?

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ___

Additional comments:

Other special instructions: