

IMMUNIZATION HISTORY: Fill in the MO/DAY/YR information for children 2 months of age and older. If child received a combined shot (like Hib-hep B), write the date in all the boxes that apply. Vaccine doses that are circled **O** are not required by law.

Vaccine	Dose	MO	DAY	YR
Diphtheria, Tetanus, Pertussis (DTaP) • 3 doses during 1st year (at 2-month intervals) • 4th dose at 12-18 months • 5th dose at 4-6 years or at school entrance <i>Indicate vaccine type: DTaP or DT.</i>	1			
	2			
	3			
	4			
	5			
Polio (IPV and/or OPV) • 3 doses at 2-18 months • 4th dose at 4-6 years or at school entrance	Dose	MO	DAY	YR
	1			
	2			
	3			
Measles, Mumps, Rubella (MMR) • Required for children 15 months and older • Must be given on or after 1st birthday • 2nd dose at 4-6 years	Dose	MO	DAY	YR
	1			
	2			
	3			
Haemophilus influenzae type b (Hib) • 3-4 doses for children at 2-15 months • 1 dose given after 12 months or older required • 1 dose for previously unvaccinated children 15-59 months • Not indicated for children 5 years or older	Dose	MO	DAY	YR
	1			
	2			
	3			
Varicella (Chickenpox) • 1st dose between 12-18 months • 2nd dose at 4-6 years or at school entrance (required for kindergarten)	Dose	MO	DAY	YR
	1			
	2			
	3			
Disease Date:				
Pneumococcal Conjugate Vaccine (PCV) • 2-4 doses for children 2-24 months • Consider for unvaccinated children at 24-59 months in child care • Not indicated for children 5 years or older	Dose	MO	DAY	YR
	1			
	2			
	3			
Hepatitis B (Hep B) —required for kindergarten • 3 doses between birth and 18 months	Dose	MO	DAY	YR
	1			
	2			
	3			
Rotavirus • 2-3 doses between 2 and 6 months	Dose	MO	DAY	YR
	1			
	2			
	3			
Influenza (LAIV or TIV) • 1 dose annually for children 6 months or older (1st time influenza immunization requires 2 doses)	Dose	MO	DAY	YR
	1			
	2			
	3			
Hepatitis A (Hep A) • 2 doses separated by 6 months for children 12-24 months	Dose	MO	DAY	YR
	1			
	2			
	3			

Child Care Immunization Record

Must be on file before a child attends child care.

Name: _____ Date of Enrollment: _____
 Birthdate: _____
SIGNATURE(S)

A. For children who are 15 months or older and who have received all the immunizations required by law for child care:
 I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.
 Signature of Parent/Guardian or Physician/Nurse Practitioner/Physician Assistant/Public Clinic _____ Date _____

B. For children who are younger than 15 months OR have not received all required immunizations:
 I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date.
 Signature of Physician/Nurse Practitioner/Physician Assistant/Public Clinic _____ Date _____

C. For children who have a history of disease or are medically exempt from vaccine (s):
 The following immunization(s) are not indicated because of medical reasons, history of disease, or laboratory confirmation of adequate immunity: **(See below for varicella disease.)**

 Signature of Physician/Nurse Practitioner/Physician Assistant _____ Date _____
Starting September 2010 (Before September 2010, a parent can sign.):
 For children who are 18 months or older who have a history of varicella disease:
 I certify that varicella immunization is not indicated for the above-named child due to a history of varicella disease that I have diagnosed or had adequately described to me by the parent to indicate past varicella infection in _____ year
 Signature of Physician/Nurse Practitioner/Physician Assistant (Before September 2010, a parent can sign.) _____ Date _____

D. If the parent/guardian conscientiously opposes immunizations:
 I understand that not following vaccination recommendations may endanger the health or life of my child and others that my child might come in contact with. I hereby certify by notarization that:
 I am opposed to all immunizations.
 I am opposed to only the vaccines indicated. Vaccine(s) I oppose: _____
 Signature of Parent/Guardian _____ Date _____
 Subscribed and sworn to before me this _____ day of _____, 20____
 Signature of notary public (A copy of the notarized statement will be forwarded to the commissioner of health.) _____
 Notary Public Stamp