IMMUNIZATION RECORD

These requirements can be waived only if a properly signed health, religious or personal conviction waiver is filed with the daycare.

This form is for _____ Child's Name

Completed by _____ (Parent name)

*It is anticipated that varicella vaccine or history of disease will be required for students entering daycare and kindergarten in IMMUNIZATION HISTORY List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE AN (X). If you do not have an immunization record for this student at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE:

DTP/DTaP/DT/Td (Diphtheria, Tetanus, Pertussis) (For children entering kindergarten, at least one dose of DTP/DTaP/DT vaccine must be after the 4th birthday. Children in grades 1-12 who have received the third or subsequent doses after the 4th birthday meet the requirement.)

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Third Dose __/__/__ mo/day/yr

Fourth Dose __/__/__ mo/day/yr

Fifth Dose __/__/__ mo/day/yr

Polio (If child received the third dose after the 4th birthday, further doses are not required.)

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Third Dose __/__/__ mo/day/yr

Fourth Dose __/__/__ mo/day/yr

Fifth Dose __/__/__ mo/day/yr

HIB (Hemophilus Influenza B) (HIB vaccine is only required for children in licensed day care centers.)

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Third Dose __/__/__ mo/day/yr

Fourth Dose __/__/__ mo/day/yr

Fifth Dose __/__/__ mo/day/yr

Hepatitis B

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Third Dose __/__/__ mo/day/yr

MMR (Measles, Mumps, Rubella) (MMR must be received on or after 1st birthday.)

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Varicella (Chickenpox) Note: Vaccine is needed only if your child has not had chickenpox disease. See below.

First Dose __/__/__ mo/day/yr

Second Dose __/__/__ mo/day/yr

Has your child had Varicella (chickenpox) disease? Check the appropriate blank and provide the year if known: ___ Yes _____ year (Vaccine not needed) ___ NO or Unsure (Vaccine needed)

WAIVERS: For health reasons this student should not receive the following immunizations: _____ (Please list above any immunizations already received). Physician Signature: _____

For religious reasons this student should not be immunized. (Please list above any immunizations already received). _____

For personal conviction reasons this student should not be immunized. (Please list above any immunizations already received). This form is complete and accurate to the best of my knowledge. x_____

Signature of Parent/Legal Guardian and Date