CHILD CARE LEARNING CENTERS

THIS FORM MUST BE COMPLETED BY A LICENSED MEDICAL PERSONNEL FOR ATTENDANCE AT THE CENTER

Child's Name _____,_____
Last First MI

Sex: [ ] Male [ ] Female Age _____ Birthdate _____
Month/Day/Year

Parent or Guardian Name _____,_____
Last First MI

Address _____ City _____ Zip _____

County _____

RECORD OF IMMUNIZATION

DOSE NUMBER	DTaP MO/DAY/YR	HepB MO/DAY/YR	Hib MO/DAY/YR	MMR* MO/DAY/YR	PCV MO/DAY/YR	Polio MO/DAY/YR	Td M0/DAY/YR	Varicella MO/DAY/YR
1ST DOSE								
2ND DOSE								
3RD DOSE								
4TH DOSE								
5TH DOSE								

*Blood test verification of immunity and date may be entered in lieu of vaccination date.

I have examined the above child. Date of last examination _____

Any restrictions? [ ] Yes [ ] No (If yes, please list and describe restrictions)

_____

_____

_____

SIGNATURE OF LICENSED MEDICAL PERSONNEL _____

PRINTED _____ TITLE _____

ADDRESS _____ PHONE _____ DATE _____

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