

IMMUNIZATION RECORD Please record the dates your child received the following immunizations.

DPT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Hib 1. _____ 2. _____ 3. _____ 4. _____

Polio 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Hepatitis B 1. _____ 2. _____ 3. _____

MMR#1 _____ MMR#2 _____

Measles _____ Rubella _____ Mumps _____

Tetanus, Diphtheria Booster _____

Insurance Policy Name _____ Policy Number _____

Physician Name _____ Physician Phone _____

Parents Phone (Daytime) _____ (Evening) _____

(cell) _____ (email) _____

Allergies (if any) _____

Any known drug sensitivities? (Penicillin, etc) _____

Are there any over-the-counter products you do not want given to your child? (Tylenol, Pepto-Bismol)

Please specify: _____

If you have a preference for the treatment of the following conditions, please specify:

Headache _____

Stomachache _____

Sunburn _____

Rash _____

Insect Bites _____

Are there any special conditions we should know about? Please mention any prescription medication your child will need and the time of administration. The staff nurse will administer these medications. (Send in Rx container with the name and dosage.)

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

Signatures of both parents, custodians or legal guardians of the above named child are required. Both parents must sign or in the case of divorce, the parent with custody. Release must be signed before the child can participate in the above referenced activity.