HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

_____

What is the status of the child's. . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

MS-2083

Child Care Immunization Record

*Must be on file **before** a child attends child care.*

Name: _____

Birthdate: _____ Date of Enrollment: _____

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 enrolle 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

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 ◯ are not required by law.

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