Day Care Center Immunization Check List

Date of Assessment_____

_____
Name of Day Care Facility

_____
Operators Name

_____

Address & Phone number

_____

Varicella/VZV: Chicken Pox
DTaP: Diphtheria, Tetanus Pertussis
DT: Diphtheria, Tetanus
Polio: IPV or OPV
HepB: Hepatitis B
HIB: Haemophilus Influenzae type b
MMR: Measles, Mumps, Rubella
PCV: Infant Pneumococcal
HepA: Hepatitis A
Other: Vaccine Name_____

EXEMPTIONS: ONLY medical exemptions are allowed.

Child's Name (include middle initial)	**DOB**											
		DTaP#1	**DTaP#2**	**DTaP#3**	**DTaP#4**	**DTaP#5**		**Polio#1**	**Polio#2**	**Polio#3**	**Polio#4**	
Doctor Name:		**HIB#1**	**HIB#2**	**HIB#3**	**HIB#4**		**MMR#1**	**MMR#2**		**HepB#1**	**HepB#2**	**HepB#3**
Clinic Name:		**PCV#1**	**PCV#2**	**PCV#3**	**PCV#4**	**Var/VZV**	**Var/VZV**	**HepA#1**	**Hep A #2**	**Other**	**Other**	**Other**
Child's Name (include middle initial)	**DOB**											
		DTaP#1	**DTaP#2**	**DTaP#3**	**DTaP#4**	**DTaP#5**		**Polio#1**	**Polio#2**	**Polio#3**	**Polio#4**	
Doctor Name:		**HIB#1**	**HIB#2**	**HIB#3**	**HIB#4**		**MMR#1**	**MMR#2**		**HepB#1**	**HepB#2**	**HepB#3**
Clinic Name:		**PCV#1**	**PCV#2**	**PCV#3**	**PCV#4**	**Var/VZV**	**Var/VZV**	**HepA#1**	**Hep A #2**	**Other**	**Other**	**Other**
Child's Name (include middle initial)	**DOB**											
		DTaP#1	**DTaP#2**	**DTaP#3**	**DTaP#4**	**DTaP#5**		**Polio#1**	**Polio#2**	**Polio#3**	**Polio#4**	
Doctor Name:		**HIB#1**	**HIB#2**	**HIB#3**	**HIB#4**		**MMR#1**	**MMR#2**		**HepB#1**	**HepB#2**	**HepB#3**
Clinic Name:		**PCV#1**	**PCV#2**	**PCV#3**	**PCV#4**	**Var/VZV**	**Var/VZV**	**HepA#1**	**Hep A #2**	**Other**	**Other**	**Other**