Child Immunization Record

Firstep Evaluations

Child's Name: ______________________ Sex: ______________________

Birth date: ______________________

Phone: ______________ Parent or Guardian: ______________________

Address: ______________________

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Immunization

Vaccine	Date Given dd/mm/year	Doctor or Clinic	Date Next Dose Due
DTP			
Polio IPV			
MMR			
HIB *if possible specify vaccine HBOC, PRP-OMP, or PRP-D*			
HB (at birth)			
HBIG (at birth)			
Hep B			
Other			

Exemptions

if a child cannot or should not receive a particular immunization, write one of the following reasons in the "Doctor or Clinic" column.

(a) HAS HAD DISEASE (Attach physician's note.) For Rubella only a serologic test is a valid exemption.

(b) ALLERGIC TO ______________ (Specify allergen and attach physician's note.)

(c) PARENT WILL NOT GIVE CONSENT (Please attach letter from parent.)