

Name of Child _____

Date of Birth _____

Name(s) of Parent(s) _____

Doctor/Office Staff:

1. Enter the date an immunization was received in the space below **OR** attach a copy of the immunization record.
2. Please sign below to confirm immunizations are current.

Enter date of each dose – Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DT (circle which)					
*Polio					XXXXXXXXXX
**Hib					XXXXXXXXXX
***Hepatitis B				XXXXXXXXXX	XXXXXXXXXX
*MMR (combined doses)			XXXXXXXXXX XXXXXXXXXX	XXXXXXXXXX XXXXXXXXXX	XXXXXXXXXX XXXXXXXXXX
****Combined Pox					
OTHER					
OTHER					

* Required by State Law.

** Required by State law for children born on or after 10/1/88.

*** Required by State law for children born on or after 7/1/94.

**** Required by State law for children born on or after 4/1/01.

G.S. 130A-155(b) requires all child care facilities to have this information on file.

I certify that this child, according to our records, is current on all required vaccinations.

Doctor's Signature _____ Date _____

Address _____