Provider Name: Daviess County Family YMCA

THIS FORM MUST BE COMPLETED

Child Immunization Record

Child's Name _____Date of Birth_____

Parent's Name _____ Phone _____

Address_____

Record the Date of Immunization

	1	2	3	4	5
Hep B				XXXXX	XXXXXX
DtaP / DTP / Td					
Hib					XXXXXX
MMR			XXXXXX	XXXXXX	XXXXXX
OPV					XXXXXX
Varicella		XXXXXX	XXXXXX	XXXXXX	XXXXXX
PCV / Prevanar					XXXXXX

Child has documented history of varicella disease ___No ___Yes If yes, age

***Please note varicella or documented immunity (chicken pox) are required for participation in the CCDF program. PCV/Prevanar is also required when age appropriate.**

Please check the appropriate response
___ Child has received complete age-appropriate immunizations.
___ Child is currently in the process of receiving complete age-appropriate immunizations

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Comments: *(Please list immunizations excluded for medical reasons)*

_____
_____
_____

Parent comments: (Please indicate religious objection, if any)

_____
_____
_____

Signed _____Date_____

Health Care Provider's Signature

Printed Name and Title _____
_____

This form shall be updated annually