

Immunization History

Name: _____ Date of Birth _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose – Month/Day/Year

Vaccine	#1	#2	#3	#4	#5
*DTP/DT (Circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
****Chicken 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.**

Records Updated by:	Date Updated:

Physicians Signature _____ Date _____