Child Care Immunization Record

*Must be on file **before** a child attends child care.*

Name: _____

Birthdate: _____ Date of Enrollment: _____

IMMUNIZATION HISTORY: Fill in the MO/DAY/YR information for children 2 months of age and older. If child received a combined shot (like Hib-hep B), write the date in all the boxes that apply. Vaccine doses that are circled ◯ are not required by law.

Diphtheria, Tetanus, Pertussis (DTaP)	Vaccine	Dose	MO	DAY	YR
• 3 doses during 1st year *(at 2-month intervals)* • 4th dose at 12-18 months • 5th dose at 4-6 years or at school entrance *Indicate vaccine type: DTaP or DT.*		1			
		2			
		3			
		4			
		⑤			

Polio (IPV and/or OPV)	Vaccine	Dose	MO	DAY	YR
• 3 doses at 2-18 months • 4th dose at 4-6 years or at school entrance		1			
		2			
		3			
		④			

Measles, Mumps, Rubella (MMR)	Vaccine	Dose	MO	DAY	YR
• Required for children 15 months and older • Must be given on or after 1st birthday • 2nd dose at 4-6 years		1			
		②			

Haemophilus influenzae type b (Hib)	Vaccine	Dose	MO	DAY	YR
• 3-4 doses for children at 2-15 months • 1 dose ≥12 months required (suspended 2008*) • 1 dose for previously unvaccinated children 15-59 months • Not indicated for children 5 years or older		1			
		2			
		③			
		④			

Varicella (Chickenpox)	Vaccine	Dose	MO	DAY	YR
• 1st dose between 12-18 months • 2nd dose at 4-6 years or at school entrance (required for kindergarten)		1			
		②			
	Disease Date:				

Pneumococcal Conjugate Vaccine (PCV)	Vaccine	Dose	MO	DAY	YR
• 2-4 doses for children 2-24 months • Consider for unvaccinated children at 24-59 months in child care • Not indicated for children 5 years or older		1			
		2			
		3			
		4			

Hepatitis B (Hep B)–required for kindergarten	Vaccine	Dose	MO	DAY	YR
• 3 doses between birth and 18 months		①			
		②			
		③			

Rotavirus	Vaccine	Dose	MO	DAY	YR
• 2-3 doses between 2 and 6 months		①			
		②			
		③			

Influenza (LAIV or TIV)	Vaccine	Dose	MO	DAY	YR
• 1 dose annually for children ≥6 months (1st time influenza immunization requires 2 doses)		①			
		②			

Hepatitis A (Hep A)	Vaccine	Dose	MO	DAY	YR
• 2 doses separated by 6 months for children 12-24 months		①			
		②			

* Suspended due to vaccine shortage 2008

SIGNATURE(S)

A. For children who are 15 months or older and who have received all the immunizations required by law for child care:

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

_____

Signature of Parent/Guardian or Physician/Nurse Practitioner/Physician Assistant/Public Clinic Date

B. For children who are younger than 15 months or who have not received all the immunizations required by law for child care:

I certify that the above-named child has received the immunizations indicated to the left,

☐ which includes beginning the immunization series required by law for child care that must be completed within 18 months of starting them (DTP, polio, pneumococcal),

and/or

☐ the following immunization(s) are not indicated because of medical reasons, history of disease, or laboratory confirmation of adequate immunity: **(Starting September 2010 for varicella disease see C.)**

_____

_____

Signature of Physician/Nurse Practitioner/Physician Assistant Date

C. Starting September 2010 (Before September 2010, a parent can sign.): For children who are 18 months or older who have a history of varicella disease:

I certify that varicella immunization is not indicated for the above-named child due to a history of varicella disease that I have diagnosed or had adequately described to me by the parent to indicate past varicella infection in _____.
year

_____

Signature of Physician/Nurse Practitioner/Physician Assistant (Before September 2010, a parent can sign.) Date

D. If the parent/guardian conscientiously opposes immunizations:

I understand that not following vaccination recommendations may endanger the health or life of my child and others that my child might come in contact with. I hereby certify by notarization that:

☐ I am opposed to all immunizations.

☐ I am opposed to only the vaccines indicated. Vaccine(s) I oppose:

_____

_____

Signature of Parent/Guardian Date

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Signature of Notary Public *(A copy of the notarized statement will be forwarded to the commissioner of health.)*

Notary Public Stamp

Minnesota Immunization Program: 651-201-5503 or 1-800-657-3970 (MDH, 4/2010)