RECORD OF CHILDHOOD IMMUNIZATIONS

Wee Wisdom Nursery School & Child Care Center, Inc.

Instructions to Parents:

- *Please have your health care provider fill out this form completely.*
- *This form must be completed, current, and submitted to Wee Wisdom prior to your child's first day of attendance.*
- *Note the summary of Immunization Requirements noted below*

Summary of Immunization Requirements

Ages 2-5 Years	Kindergarten through Grade 6
4 DTaP/DT/Td/TD	5 DTaP/DT/Td/TD
3 IPV	3 IPV
4 Hib (or Comvax)	4 Hib (or Comvax)
3 Hepatitis B	3 Hepatitis B
1 MMR (on of after 1st Birthday)	2 MMR (2nd dose prior to Kdg)
1 Varicella (Varivax)	1 Varicella (Varivax) (by age 11)
4 PCV (Pneumococcal, Conjugate, or Prevnar)	0 PCV (if age 5 or over exempt)

★ If your child has already had chicken pox, the Varicella vaccination is **not** required.

★ My child, listed below, has had chicken pox during the following month and year:
____/______ (month/year).

Child's __Full__ Name: ___________________________________ Birth Date: _________

EXEMPTIONS:

☐ The above child has a medical condition that is contraindicated for him/her to receive the following immunization(s) for the following reasons:

Immunization	Reason

☐ Permanent Condition
☐ Temporary Condition: until _______________ (Mo/Day/Yr)

This exemption will not pose a medical threat to the child listed above or any other child with whom he or she comes into contact.

____ ______________________

Physician's Signature ***Date***

Wee Wisdom Nursery School & Child Care Center, Inc.
Revised 09/06

Child's Full Name: ___________________________________ Birth Date: _________

☐ As the custodial parent of the child listed above, I object to the following immunization(s) based on religious beliefs and/or practices.

____ ____________________
Parent's Signature ***Date***

IMMUNIZATION RECORD

Please list Month, Day, and Year for each dose given.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP/DT/DTP/td					
IPV					N/A
HIB/Comvax					N/A
Hep B				N/A	N/A
MMR			N/A	N/A	N/A
Varicella			N/A	N/A	N/A
Pneumococcal					N/A

Name of Health Care Provider completing form:

____

Printed Name of Physician: _______________________________________

Physician Phone Number: ____________________________

____ ____________________
Parent's Signature ***Date***

★ **MUST BE AN ORIGINAL SIGNATURE**