TO BE COMPLETED BY A HEALTH CARE PROVIDER

Immunization Record

This form must be completed prior to your child's first day of attendance.

This form must be updated annually.

Child's full name _____ Birthdate_____/_____/_____

Parent/Guardian name _____ Phone _____

Camp attending _____

Hep B					
DtaP/ DTP/ Td					
Hib					
MMR					
IPV					
Varicella (Chicken Pox)					
PCV / Prevanar					

Date of last Tetanus shot _____

Child has documented history of Chicken Pox?_____ No _____Yes If yes, age _____

Parent Comments: (Please indicate religious objections, if any.)_____

_____

_____

Health Care Provider Comments: (Please list immunizations excluded for medical purposes.) _____

_____

_____

Please check the appropriate response:

_____ Child has received age-appropriate immunizations.

_____ Child is currently in the process of receiving age-appropriate immunizations.

Signed _____ Date _____

Health Care Provider's Signature

Printed Name and Title _____