Family Development Services

~A Head Start Organization~

Head Start Child Immunization Record

Child Name: _____ **Date of Birth:** _____/_____/_____

First Last

Immunization Schedule Used: _____

Immunizations	1st	2nd	3rd	4th	5th	6th	Next Due	Status	Medical Exemption	Serological Immunity	Confirmation Date
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
DtaP/DTP	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
Hib Type: _____	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
Polio Type: _____	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
MMR	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
Pneumococcal (PCV)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___
Varicella	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__				___/___/___

MEDICAL EXEMPTION WAIVER ☐ **RELIGIOUS EXEMPTION** ☐

*** Please use back of form for general comments.**

Provider's Name Address: _____ **Provider's Signature:** _____

Date: _____

2009-2010