

## Inoculation Records

I understand that it is my responsibility to ensure that I provide the daycare with an up to date copy of all childhood immunizations from the current health care provider. Please check the inoculations that have been given to your child along with the date and physician.

Diphtheria / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Whooping Cough / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Tetanus / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Measles / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Rubella / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Poliomyelitis / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Varicella / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

Prevnar / Date of shot (mm/yr) \_\_\_\_/\_\_\_\_  
Physician admin \_\_\_\_\_  
Phone: \_\_\_\_\_

\_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_\_

(Signature of parent or guardian)

\_\_\_\_\_

Name of child (Please submit one form for each child)