IMMUNIZATION FORM

STATE FORM 49445 (R5 / 01-25)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

HISTORY OF IMMUNIZATIONS (*indicate month and year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* **Influenza (Flu)**					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
* **Rotavirus (RGE)**			

	1	2		
Varicella (Varivax)			**or Chicken Pox Disease**	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
* **HEPA**		

	1	2	3
HBV (HEP B)			

* Not required but highly recommended.

Name of physician / nurse practitioner completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner	

Name of child	Date of birth (*month, day, year*)	Age
Name of child care facility		County

ADDITIONAL NOTES AND INSTRUCTIONS