Emergency Information and Immunization Record Card

Child's Name: _____ Date of Enrollment: _____ Updated: _____

Street Address: _____ Date of Disenrollment: _____

City, State & Zip Code: _____ Date of Birth: _____ Sex: □male □female

Mother or Guardian:
Name: _____

Home Address: _____

Hm. Ph: _____ Cell Ph: _____

Business Name: _____

Business Address: _____

Wk. Ph: _____

Signature:_____

Father or Guardian:
Name: _____

Home Address: _____

Hm. Ph: _____ Cell Ph: _____

Business Name: _____

Business Address: _____

Wk. Ph: _____

Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Address Phone

HOSPITAL:_____
Name Address Phone

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____ Name: _____

Address: _____ Address: _____

Ph: _____Cell Ph:_____ Ph: _____Cell Ph:_____

Name: _____ Name: _____

Address: _____ Address: _____

Ph: _____ Cell Ph:_____ Ph: _____ Cell Ph:_____

The following person(s) may **not** remove my child from the facility:

Name: _____ Name: _____

Custody papers have been provided and are on file at the facility. □ yes □ no

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent or Guardian printed name: _____

Signature: _____ **Date:** _____

Immunization Information

	Required Vaccine Doses By Age					
Age	**DtaP**	**Polio**	**Hib**	**Hepatitis B**	**Hepatitis A**	**MMR**
<2 months				#1		
2 – 3 months	#1	#1	#1			
4 – 5 months	#2	#2	#2	#2		
6 – 11 months	#3		#2 - #3[1]			
12 – 14 months		#3	#1 - #4[2]	#3		#1
15 – 59 months	#4					
24 – 71 months					#1 - #2[3]	
School Age	#4 or #5[4]	#3 or #4[5]		3	2	

[1] Hib if Pedvax or Comvax vaccine given
[2] at least 1 Hib after 12 months of age
[3] Maricopa County only
[4] 4 doses satisfy requirement if 3rd dose after 4th birthday
[5] 3 doses satisfy requirement if 3rd dose after 4th birthday

Check one

	Copy of current official documented immunization record attached
	Religious Beliefs exemption form signed by parent/guardian attached
	Medical Exemption form signed by physician and parent/guardian attached
	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s): ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR

Updated immunizations received and attached ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR ___/___/___ MO/DAY/YR

Medical Information

Is child allergic to food or other substances? (If so, name foods or substances to be avoided and procedure to follow if reaction occurs.)

_____

Is child usually susceptible to infections and if so, what precautions need to be taken?_____

_____

Is child subject to convulsions and what should be our procedure if one occurs? _____

_____

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? _____

_____

Additional comments: _____

_____

_____

Other special instructions: _____

_____

_____