

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: _____

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Business Address: _____

Signature: _____

Father or Guardian:

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Business Address: _____

Signature: _____

If Medical Care is Necessary, Call:

DOCTOR:

Name Address Phone

HOSPITAL:

Name Address Phone

Does your child have insurance coverage? ☐ yes ☐ no

Name of Insurance Company _____
(Optional)

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: _____

Telephone: _____ Cell phone: _____

Telephone: _____ Cell phone: _____

Name: _____

Name: _____

Address: _____

Address: _____

Telephone: _____ Cell phone: _____

Telephone: _____ Cell phone: _____

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

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	Varicella
<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	#1
15 – 59 months	#4						
24 – 71 months					#1 ³ & #2 ³		
School Age (K-12)	#4 ⁴ or #5	#3 ⁵ or #4		#3		#2 ⁶	#1 ⁷

¹ Pedvax or Comvax vaccine given

² Must have at least 1 Hib after 12 months of age

³ Hep A required in Maricopa County only

⁴ 4 doses meet requirement if 4th dose is after 4th birthday

⁵ 3 doses meet requirement if 3rd dose is after 4th birthday

⁶ Must have 2 doses of MMR for K-12 entry

⁷ A 2nd dose is needed if dose #1 is given at 13+ years of age

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:_____

Telephone Authorization Code:_____ (optional)