

# 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

Age	Required Vaccine Doses By 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 <sup>1</sup>			
12 – 14 months		#3	#1 - #4 <sup>2</sup>	#3		#1
15 – 59 months	#4					
24 – 71 months					#1 - #2 <sup>3</sup>	
School Age	#4 or #5 <sup>4</sup>	#3 or #4 <sup>5</sup>		3	2	

<sup>1</sup> Hib if Pedvax or Comvax vaccine given

<sup>2</sup> at least 1 Hib after 12 months of age

<sup>3</sup> Maricopa County only

<sup>4</sup> 4 doses satisfy requirement if 3<sup>rd</sup> dose after 4<sup>th</sup> birthday

<sup>5</sup> 3 doses satisfy requirement if 3<sup>rd</sup> dose after 4<sup>th</sup> birthday

### Check one

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	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:

\_\_\_\_\_

\_\_\_\_\_