Emergency Information and Immunization Record Card

Child's Name: _____ Date Enrolled: _____ Updated: _____

Home Address: _____ Date Disenrolled: _____
Street City State Zip

Home Phone: _____ Date of Birth: _____ Sex: male female

Mother or Guardian
Name: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Business Address: _____
Street City State Zip

Signature: _____

Father or Guardian
Name: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Business Address: _____
Street City State Zip

Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Address City State Zip Phone

HOSPITAL: _____
Name Address City State Zip Phone

Does your child have insurance coverage? ☐ **No** ☐ **Yes** 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: _____
Street City State Zip Street City State Zip

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

Name: _____ Name: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

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:

_____ **Date:** _____
Parent or Guardian printed name Signature

Immunization Information

Age	Required Vaccine Doses By 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? ☐ **No** ☐ **Yes** (If yes, 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? ☐ **No** ☐ **Yes** _____

Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** _____

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.)? ☐ **No** ☐ **Yes** _____

Additional comments: _____

Other special instructions: _____

Telephone Authorization Code : _____ (optional)