**Name of Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name(s) of Parent(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor/Office Staff:**

1. ***Enter the date an immunization was received in the space below* OR *attach a copy of the immunization record.***
2. ***Please sign below to confirm immunizations are current.***

**Enter date of each dose – Month/Day/Year**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE** | **#1** | **#2** | **#3** | **#4** | **#5** |
| \*DTP/DT  (circle which) |  |  |  |  |  |
| \*Polio |  |  |  |  | XXXXXXXXXX |
| \*\*Hib |  |  |  |  | XXXXXXXXXX |
| \*\*\*Hepatitis B |  |  |  | XXXXXXXXXX | XXXXXXXXXX |
| \*MMR  (combined doses) |  |  | XXXXXXXXXX  XXXXXXXXXX | XXXXXXXXXX  XXXXXXXXXX | XXXXXXXXXX  XXXXXXXXXX |
| \*\*\*\*Combined Pox |  |  |  |  |  |
| OTHER |  |  |  |  |  |
| OTHER |  |  |  |  |  |

|  |  |
| --- | --- |
|  |  |
| \* | Required by State Law. |
| \*\* | Required by State law for children born on or after 10/1/88. |
| \*\*\* | Required by State law for children born on or after 7/1/94. |
| \*\*\*\* | Required by State law for children born on or after 4/1/01. |

G.S. 130A-155(b) requires all child care facilities to have this information on file.

**I certify that this child, according to our records, is current on all required vaccinations.**

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_