

# 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 <sup>1</sup>				
12 – 14 months		#3	#1 - #4 <sup>2</sup>	#3		#1	#1
15 – 59 months	#4						
24 – 71 months					#1 <sup>3</sup> & #2 <sup>3</sup>		
<b>School Age (K-12)</b>	#4 <sup>4</sup> or #5	#3 <sup>5</sup> or #4		#3		#2 <sup>6</sup>	#1 <sup>7</sup>

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

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

<sup>3</sup> Hep A required in Maricopa County only

<sup>4</sup> 4 doses meet requirement if 4<sup>th</sup> dose is after 4<sup>th</sup> birthday

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

<sup>6</sup> Must have 2 doses of MMR for K-12 entry

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

**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: \_\_\_\_\_

\_\_\_\_\_

**Telephone Authorization Code:** \_\_\_\_\_ (optional)