HISTORY OF IMMUNIZATIONS

State Form 49445 (R4 / 4-12)

HISTORY OF IMMUNIZATIONS (*Indicate month and year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
* Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
* HEPA		

	1	2	3
HBV (HEP B)			

* Not required but highly recommended.

Name of physician / nurse practitioner completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner	

Name of child	Date of birth (*month, day, year*)	Age
Name of child care facility	County	

ADDITIONAL NOTES AND INSTRUCTIONS