

# 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: \_\_\_\_\_  
Street City State Zip

Address: \_\_\_\_\_  
Street City State Zip

Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Address: \_\_\_\_\_  
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:

Parent or Guardian printed name

Signature

Date: \_\_\_\_\_

## 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 <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? ☐ 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)