

CHILD HEALTH RECORD

State of Connecticut
 Department of Public Health
 Child Day Care Licensing Program
 1-800-282-6063; 1-800-439-0437

Child's Name _____ Date of Birth _____ Home Phone _____

Parents/Guardian _____ Address _____

IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION	DATE					IMMUNIZATION	DATE
	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE		
DTP/DTaP/DT						MMR (1st Dose)	
OPV/IPV						MEASLES (2nd Dose)	
Hib (HAEMOPHILUS INFLUENZA TYPE B)						VARICELLA (Chicken Pox) (Recommended)	
HEPATITIS B						OTHER (Specify)	

Are there medical contraindications to immunization for this child? Yes No
 If yes, specify the vaccine(s) and indicate the contraindications specified in the vaccine manufacturers package insert that applies to this child: _____

Does this child have laboratory confirmed proof of immunity to natural infection? Yes No
 If yes, please explain and attach laboratory report: _____

Is this child current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? (Connecticut General Statute 19a-7f) Yes No

GENERAL HEALTH RECORD:

Height _____ Weight _____

DATE OF EXAM: _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affect the child's functional ability to participate safely in a day care setting: _____

Medical information pertinent to routine child care and emergencies: _____

Is this child taking prescription medication on a daily basis for a chronic illness/condition? YES NO
 If yes, indicate prescription.
 Does the child have allergies? YES NO Explain: _____

Is the child on a special diet? YES NO Explain: _____

The next appointment for immunization is scheduled for: _____
 (Required unless contraindicated, proof of immunity, or contrary to religious beliefs) (Month/Day/Year)

Medical Care Provider (Name, Address, Telephone #): _____

 Signature of MD, APRN or PA

CONNECTICUT IMMUNIZATION SCHEDULE

This chart shows acceptable age ranges for shots. Ask your health-care provider to tell you when your child should get shots. For *Immunization questions* only call 1-860-509-7929.

CHILD'S AGE	SHOT(S)
Birth - 2 months	Hep B #1 (hepatitis B)
1-4 months	Hep B #2 - at least 1 month after Hep B #1
2 months	DTP/DTaP/DT #1 (diphtheria, tetanus and pertussis), OPV/IPV #1 (polio), Hib #1 (Haemophilus influenzae type b)
4 months	DTP/DTaP/DT #2, OPV/IPV #2, Hib #2
6 months	DTP/DTaP/DT #3, Hib #3
6-18 months	Hep B#3, OPV/IPV #3
12-15 months	Hib #4, MMR #1 (measles, mumps and rubella)
12-18 months	DTP/DTaP/DT #4, Varivax(varicella/chickenpox vaccine - not required at this point in time)
Before starting school (4-6 years)	DTP/DTaP/DT #5, OPV/IPV #4
11-12 years	Varivax (if your child has not had the chickenpox shot, and has never had chickenpox), Hep B (if your child has not had the hepatitis B shots), MMR #2 - A second dose of measles is required for entry into 7th grade
11-16 years	Td (tetanus, diphtheria)

*Effective August 29, 1996, Hepatitis B vaccine is required for all enrolled children born after December 31, 1993. Hepatitis B information is being collected on two age groups of children. Detailed information is found in the instructions.

Required Immunizations - Musts be given by the end of the stated month of life listed under "CHILD'S AGE". For example, immunizations required at two months must be given prior to the child turning three months in order for the child to continue in the program.