FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

START DATE:

_____/_____/_____
Month Day Year

Lower Bucks Family YMCA
Fairless Hills Branch
601 S. Oxford Valley Road
Fairless Hills, PA 19030
www.lbfymca.org
215-949-3400

2018-2019 SCHOOL AGE CHILD CARE

Child's Name: _____ **DOB:** ___/____/____ **Circle:** Male/Female

Child's School: _____ **Grade:**_____

Desired Care Location: _____(***see page 2 for schools***)

Please choose your desired school-year schedule below. **Important note**:

- By selecting specific days of the week, you are committing to this schedule for the entire school-year. Any changes to your selection, including cancellation, must be made by the Thursday prior to the upcoming week of care.
- All payments are also due by the Thursday prior to the upcoming week of care.
- As transportation is included for students of the Neshaminy and Pennsbury School Districts, participants are limited to a 3-day or 5-day option.
- The Director of School Age Child Care will run rosters every Friday prior to the upcoming week of care. Only those children listed on the roster, with a zero balance, will be accepted into Morning Care or After Care for the upcoming week.

Please indicate choice by placing an "x" in boxes below:

	Monday	Tuesday	Wednesday	Thursday	Friday	*Drop-In Flexibility Program ***Brookwood, Keystone, Mill Creek ONLY***
Before Care						
After Care						

***I understand that by choosing the Drop-In Flexibility Program, I MUST register for the days I need care, by no later than the THURSDAY prior to the upcoming week of needing care. I can register at the Welcome Center of the Fairless Hills Branch or online. I further understand that the Director of School Age Child Care will run rosters for the Drop-In Flexibility Program on the FRIDAY prior to the upcoming week of care. Only those children listed on the roster, with a zero balance, will be accepted into Morning Care or After Care for the upcoming week. This is for the safety of all children and their families.*

I further acknowledge the following:

- Parent/Guardian must have a current billing method on file
- Parent/Guardian will be drafted on the Thursday prior to the upcoming week of care
- A $5 late fee will be applied to all payments received after Thursday for the upcoming week of care
- See next page for fees

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Fees:

BRISTOL TOWNSHIP SCHOOL DISTRICT – SERVED AT SCHOOL SITE		
BROOKWOOD | KEYSTONE | MILL CREEK		
	Daily Fee	**5-Day Fee**
Before Care	$9	$45
After Care	$12	$60
Before and After Care	$21	$105

FAIRLESS HILLS LOCATION **Pennsbury Elementary Schools:** Oxford Valley, Fallsington, Penn Valley, Walt Disney, Manor **Neshaminy Elementary Schools:** Herbert Hoover, Walter Miller *Price is higher due to transportation. Also; due to transportation, the drop-in flexibility program is not available. Parent/Guardian must commit to a 3-day or 5-day schedule.*		
	3-Day Fee	**5-Day Fee**
Before Care	$43	$60
After Care	$56	$85
Before and After Care	$83	$130

MORRISVILLE LOCATION **Morrisville Elementary Schools:** Grandview Elementary (Grades K-2), Morrisville Intermediate School (Grades 3-5) *Price is higher due to transportation. Also; due to transportation, the drop-in flexibility program is not available. Parent/Guardian must commit to a 3-day or 5-day schedule.*		
	3-Day Fee	**5-Day Fee**
Before Care	$43	$60
After Care	$56	$85
Before and After Care	$83	$130

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Dear Parents/Guardians,

Thank you for choosing the Lower Bucks Family YMCA, *Beyond the Classroom*, School Age Child Care Program.

The goal of the program continues to be helping children grow physically, mentally and spiritually. Our program follows an activity schedule that is designed to give your child an experience that will be fun, engaging and enriching. We offer fun and challenging activities both in small and large groups. Our staff is caring and well trained to meet the needs of each child under our care. We strive to give each child an experience that will help them develop to their full potential.

Our goal is to: "Provide a healthy, safe and fun environment for all."

We strive to meet the needs of all children in our care, but we have found that occasionally there are situations that are beyond our scope of care. If we find that we are not the best fit for your child, we will help connect you with resources in the community that may better serve your needs.

A copy of our Discipline and Termination Policies are attached. More information on the policies of our program can be found in our Parent Handbook. Our Parent Handbook is now available on our website www.lbfymca.org. Please sign the acknowledgement that you have read the handbook and understand our discipline and termination policies on the financial terms and conditions form.

We look forward to serving you and your child!

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DISCIPLINE POLICY

This policy has been adopted with the safety of all of the families in YMCA child care in mind.

We understand that from time to time, all individuals need help and direction in learning, developing, and maintaining appropriate behavior. However, the YMCA expects that each individual will be or will learn to be responsible for his or her behavior, will be respectful towards others, and will act in a caring and honest manner.

If an individual exhibits frequent disruptive and/or aggressive behavior (especially if his or her actions endanger self or others) a family conference will be scheduled. Continued disruptive and/or aggressive behavior may result in temporary suspension or permanent dismissal from the program. All families need a safe, stable and enjoyable environment while at the YMCA and disruptive individuals can quickly destroy the cooperative atmosphere of a class/site.

- Children must respect each other. Taunting and teasing will not be tolerated.
- Anger and sensitivity will be diffused as best we can.
- We expect parental support when dealing with disrespectful behavior.
- We follow the rule "*keep yourself to yourself*."
- Children must not use their hands and/or feet to express themselves. Words are encouraged.
- If your School Age child hits or kicks another child deliberately, then your child will be suspended from our program for 1-3 days depending upon the severity of the infraction.
- Any further instances will result in immediate termination from the program.

TERMINATION

Under the circumstances listed below, a child may be refused admittance to the program until the situation is corrected. In some cases, services may be terminated permanently.

1. Continued, unexcused late pick-up (after closing time). A written warning will be sent after three incidents. After five unwarranted incidents, you may be asked to find another care provider for your child.
2. Failure to pay tuition on time.
3. Failure to provide required documents (health assessment, emergency contact form, signed fee agreement, etc.) within the requested time frame.
4. Inability of your child to adjust to our program after a reasonable period of time. This may apply to a child who exhibits the following behaviors: (see also "Discipline Policy).
    i. Excessive crying or tantrums
    ii. Behavior which is considered dangerous to the child or to others
    iii. Behavior which is continually disruptive to the daily program

When any of these circumstances occur, parents will be notified and asked to meet with the Site Supervisor and/or Director. Together we will try to address and manage the situation. A deadline as to when visible improvements of behavior will be agreed upon; however if no improvement is made, a decision will be made to dismiss the child.

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Financial Terms and Conditions

1. A registration fee of $50/child, $75/family and first week of payment must be made upon registration.

2. I understand that tuition is due the Thursday before service begins. Payments made after Thursday will include a $5 late fee charge. If payments fall more than two weeks behind, my child will be suspended from the program until payments are paid in full.

3. I understand that there will be a $1.00 per minute per child late fee for children not picked up by 6:05 pm. Habitual lateness may result in disenrollment.

4. I understand that the Y will not pro-rate for days children are off from school such as: holidays and personal vacations. Fees for children are to be paid whether the child is in attendance, out sick, or on vacation.

5. **If I am on ELRC subsidy**:
   a. I am responsible to remain within the allotted 40 days of absences approved by ELRC.
   b. I am further responsible for payment for any care outside of the allotted 40 absences approved by ELRC.
   c. I will be charged full price for any days I bring my child which are not approved by ELRC for subsidy. (Example: ELRC will pay for M-W-F, but parent/guardian drops child off on Thursday.)

6. I understand that refund requests due to serious illness will be considered on a case by case base basis and require a note from a physician within 1 week post illness.

7. I understand that I will incur a $30 fee for any returned bank drafts.

8. Draft is the preferred method of payment. Credit card and bank draft are accepted.

9. I acknowledge that the most up to date version of that the Parent Handbook is available online at www.lbfymca.org and I agree to abide by the all terms and conditions set forth within the handbook.

I have read and agree to the financial terms and conditions:

_____ _____ _____

Child's Name **Parent/Guardian Signature** **Date**

If you feel that you are not able to afford our program, please contact the Welcome Center for more information about financial assistance at 215-949-3400.

Last Name/First Name of Guardian: _____

Address: _____

Last Name/First Name of my Child: _____

Program my Child is in: _____

Name on Account: _____

I choose to have my weekly tuition automatically deducted on Thursdays from:

❒ Checking Account or ❒ Savings Account

❒ Keep this billing information on file, but Do NOT draft automatically. *

❒ Credit Card:

❒ Visa ❒ MasterCard ❒ American Express ❒ Discover

* If tuition payment is not received by due date (draft option NOT selected), my account will be automatically charged using the billing information on file.

Please read and sign the following:

I hereby give authority to Lower Bucks Family YMCA (LBFYMCA) to use the above information to charge me for any Child Care expenses incurred and continuous weekly tuition payments. All charges will be drafted from my account on Thursdays throughout the school year. ***I will be responsible for all payments from my account and will notify LBFYMCA of any changes to my account.*** Should any draft not be honored by my bank for any reason, I realize that I am still responsible for that payment, plus subject to any overdraft charges applied by LBFYMCA. The current return draft fee is $30.00. This is in addition to any service fee my bank may charge. I understand if payment is not received by due date, my account will be automatically charged using the billing information on file obtained at registration.

I have read and agree to these financial terms and conditions:

Signature_____ Date_____

LOWER BUCKS FAMILY YMCA - EMERGENCY CONTACT/PARENT CONSENT FORM

Child's Name _____ Birth Date ____/_____/_____ Gender _____

Address _____ City _____

State _____ Zip _____ School District _____Home Phone #_____

Parent/Legal Guardian Information

Guardian's Name #1 _____ Best phone # to reach you: _____

Address _____City _____ State _____ Zip _____ E-mail_____

Place of Employment _____ Work Address _____ Work #_____

Guardian's Name #2 _____ Best phone # to reach you: _____

Address _____City _____ State _____ Zip _____ E-mail_____

Place of Employment _____ Work Address _____ Work #_____

RESTRICTIONS, DISABILITIES OR OTHER CONCERNS List any special restrictions, medical or dietary conditions the staff should know about, including allergies (If necessary, please use the reverse side of this form.):

_____

Health Insurance Information

Health Insurance Provider _____ Policy/ID#_____

Physician - Name of child's physician to be contacted in an emergency.

Physician's Name _____ Phone #_____

Medications – List all medications your child is presently taking, including over the counter medication.

Medication_____	Medication_____	Medication_____
Dosage amount_____	Dosage amount_____	Dosage amount_____
Time taken_____	Time taken_____	Time taken_____
How often_____	How often_____	How often_____
Reason_____	Reason_____	Reason_____

Emergency Contacts - Names and phone numbers of persons to be contacted in the event a parent is not available. Your child will only be released to the guardian's listed at the top of the sheet and those authorized as a pick-up person below. A photo ID is required. Please list additional contacts on the reverse side.

Name_____ Relationship to Child _____ Phone # _____

Address:_____ | Please sign in the box if authorized to pick-up | |

Name_____ Relationship to Child _____ Phone # _____

Address:_____ | Please sign in the box if authorized to pick-up | |

Consent - Parent's signature is required for each item below to indicate parental consent.

Obtaining Emerg. Medical Care		Transportation by the YMCA	
Admin. Minor First Aid Procedure		Medications Listed Above	
Walks and Trips		Swimming and/or Wading	

AGREEMENT - To the best of my knowledge all of the information provided above is true. I believe my child to be in good health, and he/she has my permission to participate in all activities, unless otherwise specified. I hereby indemnify and hold harmless the Lower Bucks Family YMCA (Fairless Hills, Newtown, Morrisville), its staff and volunteers from all losses, claims or actions that may arise from any act, omission, event or incident of any nature, occurring while my child is engaged in any reasonable and normal activity sponsored by the YMCA.

Parent/Legal Guardian Signature _____ Date:_____

Parent/Legal Guardian Signature at Six Month Review _____ Date:_____

Emergency Contacts - Names and phone numbers of persons to be contacted in the event a parent is not available. Your child will only be released to the guardians listed at the top of the sheet and those authorized as a pick-up person below. A photo ID is required. Please list additional contacts:

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Name___________________________________ Relationship to Child _________________ Phone # ______________________

Address:____

Please sign in the box if authorized to pick-up	

Any other important information to share:

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(C); 3280.123 &.181(c); 3290.123 & 181(c)

NAME OF CHILD		
FEE AMOUNT $	PER DAY-WEEK-MONTH weekly	DAY PAYMENT TO BE MADE: The Thursday prior to care
Services to be provided as part of the daycare fee (examples: transportation, care meals, etc.)		
Care of child		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY THE GUARDIAN TO WHOM CHILD MAY BE RELEASED
LATE FEE $1.00	PER MIN-HOUR minute	
Extra services to be provided at an additional fee, if applicable:		
Field Trips		

I, the parent/guardian;

- ☐ Received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)
- ☐ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at minimum (§ 3270.121, 3280.121, 3290.121)

SIGNATURE-PARENT OR GUARDIAN DATE

SIGNATURE-OPERATOR DATE

DATE OF CHILD'S ADMISSION
DATE OF CHILD'S WITHDRAWL

6 MONTH REVIEW
SIGNATURE-PARENT OR GUARDIAN DATE

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Effective Date: January 1, 2018

Subject: Nondiscrimination in Services

To: Parents/Guardians/Clients

From: Director of Youth Education

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Lower Bucks Family YMCA
601 S. Oxford Valley Road
Fairless Hills, PA 19030

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Pa Human Relations Commission
Harrisburg Regional Office
Riverfront Office Center
1101 S. Front Street, 5th Floor
Harrisburg, PA 17104

U.S. Department of Health and Human Services
Office of Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania
DPW/Bureau of Equal Opportunity
Southeast Regional Office
Suite 5034, 801 Market Street
Philadelphia, PA 19107

_____ _____

Legal Guardian Date Y Representative Date

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

For my participation in activities to be conducted by Lower Bucks Family YMCA, I hereby give my permission and consent, now and for all time, to Lower Bucks Family YMCA, the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Lower Bucks Family YMCA, for publication, display, sale or exhibition thereof in promotions, advertising and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience at the Lower Bucks Family YMCA, I authorize, according to this Release, shall belong to Lower Bucks Family YMCA, YMCA of the USA and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; at Lower Bucks Family YMCA.

- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience, Lower Bucks Family YMCA will not be subject to any obligation of confidentiality and may be shared with and used by Lower Bucks Family YMCA, YMCA of the USA and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA;

- Lower Bucks Family YMCA, YMCA of the USA and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Lower Bucks Family YMCA.

- Lower Bucks Family YMCA, YMCA of the USA and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Lower Bucks Family YMCA for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge Lower Bucks Family YMCA, YMCA of the USA and third parties collaborating with Lower Bucks Family YMCA and/or YMCA of the USA from any and all claims in connection with the uses and reproductions of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience Lower Bucks Family YMCA as described herein. Note: Photos and videos could be included on Facebook, Twitter, in our eblasts, enewsletters, in our program guide, on our web site, and in promotional literature.

Signature: _____Printed Name: _____

Age: _____ Address: _____

I am the Mother/Father/Legal Guardian of _____ (child's name). For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Please indicate below if you do or do not wish to allow you or your child to be photographed or videotaped.

_____Yes, I or my child may be included in ALL pictures or videos.

_____ Yes, I or my child may be included in IN HOUSE pictures or videos only.

_____No, I do not allow pictures to be taken of myself/my child.

Signature of Mother/Father/Legal Guardian: _____ Date: _____

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QUESTIONNAIRE

PLEASE PRINT ALL INFORMATION

Child's Name_____
Last First MI Date of Birth Age

Home phone_____ Cell Phone_____ Work phone_____

****

Language(s) spoken at Home ___English ___Spanish ___German ___Italian
___French ___Polish ___Other_____
List

Child's primary language _____

Child's Ethnic Background

___Not Spanish/Hispanic/Latino ___Spanish/Hispanic/Latino ___Unknown Race

___Caucasian ___African American ___Asian ___Native Hawaiian/Pacific Islander

___American Indian or Alaska Native ___Other race ___More than one race

****

CURRENT HISTORY

Describe any problems in bowel/bladder control:

_____

Describe any feeding or eating problems:

_____

_____

Describe any sleeping problems:

_____

_____

Describe any behavior or discipline problems:

_____

_____

Describe any delays in or problems with language development:

_____

_____

Check if child has any of the following characteristics:

___Frequent nightmares	___Thumb sucking	___Frequent crying
___Temper tantrums	___Tics	___Stealing
___Excessively shy	___Frequent fighting	___Stubbornness
___Fearful	___Nervous	___Allergies
___Overtiredness	___Disobedient	___Awkward
___Bed wetting	___Difficulty seeing	___Nail biting
___Lying	___Difficulty hearing	

FAMILY INFORMATION

Child lives with: ___Both parents ___Mother ___Father ___ Other (_____)

Does your child have any siblings? Please list names and ages:

Name: _____ Age _____ Name:_____ Age _____

Name: _____ Age _____ Name:_____ Age _____

Name: _____ Age _____ Name:_____ Age _____

Name: _____ Age _____ Name:_____ Age _____

Other family members (give name and relationship to child) living in the home.

_____

_____

Holidays we celebrate: _____

_____

HEALTH OF CHILD

Child's Health: Comments, (e.g. allergies, diabetes, seizures, etc.):

_____

_____

Medications (including dosage) child is taking:

_____

_____

Describe any physical or health problems:

_____

_____

Have there been any accidents or long illnesses?:

_____

_____

Does your child have an IEP or an IFSP? _____

Has child received any specialized testing? _____

If yes, when?_____

By whom?_____

Why was the testing done?

_____

_____

_____

If your child currently has an IEP/IFSP it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice.

_____ **I am providing a copy of my child's IEP or IFSP.**

_____ **This is not applicable to my child.**

_____ **I am not providing a copy of my child's IEP or IFSP.**

PARENT OR GUARDIAN SIGNATURE DATE STAFF INITIAL

Please know that we use this information to better serve you and your child.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.