

EMERGENCY Information and Immunization Record Card

Child's Name: _____ Date of Enrollment: _____ Updated: _____

Student Address: _____ Date of Disenrollment: _____

City, State & Zip Code: _____ Date of Birth: _____ Sex: Male Female

Phone: (_____) _____ Grade: _____

Mother or Guardian:

Name: _____

Home Address: _____

Hm. Ph: _____

Cell Ph: _____

Business Name: _____

Business Address: _____

Wk. Ph: _____

Signature: _____

Father or Guardian:

Name: _____

Home Address: _____

Hm. Ph: _____

Cell Ph: _____

Business Name: _____

Business Address: _____

Wk. Ph: _____

Signature: _____

If medical care is necessary, call:

DOCTOR: _____
Name Address Phone

HOSPITAL: _____
Name Address Phone

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 (provide minimum of two).

Name: _____

Name: _____

Address: _____

Address: _____

Ph: _____ Cell Ph: _____

Ph: _____ Cell Ph: _____

Name: _____

Name: _____

Address: _____

Address: _____

Ph: _____ Cell Ph: _____

Ph: _____ Cell Ph: _____

Custody papers have been provided and are on file at the facility. Yes No

The following person (s) may not remove my child from the facility:

Name: _____ Name: _____

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

IMMUNIZATION AND MEDICAL INFORMATION

Required Vaccine Doses By Age						
Age	DtaP	Polio	Hib	Hepatitis B	Hepatitis A	MMR
< 2 months				#1		
2—3 months	#1	#1	#1			
4-5 months	#2	#2	#2	#2		
6-11 months	#3		#2—#3 ¹			
12-24 months		#3	#1—#4 ²	#3		#1
15-59 months	#4					
24-71 months					#1—#2 ³	
School Age	#4 or #5 ⁴	#3 or #4*		3	2	

¹ Hib if Pedvax or Comvax vaccine given

⁴ 4 doses satisfy requirement if 3rd dose after 4th birthday

² at least 1 Hib after 12 months of age

* 3 doses satisfy requirement if 3rd dose after 4th birthday

³ Maricopa County only

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 Immunization Form attached

Notification of immunization needed sent to Parent(s) or Guardian(s): / / / / / /
 MO/DAY/YR MO/DAY/YR MO/DAY/YR

Updated immunization 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 procedures 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: _____
