Health Record

Child's Name _____ Age_____ Birth date_____

Physician_____ Phone_____

Dentist _____Phone_____

Please list any allergies or health concerns St. Joan of Arc Preschool staff would benefit from knowing. _____

_____

_____.

Current medications_____

_____.

Immunizations

A doctor or public health immunization record is required with registration. Please list the month, day and year of each dose.

DTaP 1_____	IPV 1_____	HIB 1_____	HEP B 1_____
DTaP 2_____	IPV 2_____	HIB 2 _____	HEP B 2_____
DTaP 3_____	IPV 3_____	HIB 3_____	HEP B 3_____
DTaP 4_____	IPV 4_____	HIB 4_____	
DTaP 5_____			
MMR 1_____	VZV 1_____		
MMR 2_____	VZV 2_____		

DTaP includes – DtaP and DTP (Diphtheria, Tetanus, Pertussis)
DT (Diphtheria, Tetanus- Pediatric)

Td (Tetanus, Diphtheria – adult)
IPV includes- OPV (Oral Polio Vaccine)
IPV (Injectable Polio Vaccine)
HIB- Haemophilus Influenza Type B
Hep B Hepatitis B
MMR (Measles, Mumps, Rubella
VZV (Varicella)
MMRV (MMR and VZV Combined)
COMVAX (HIB Hep B Combined)