



HISTORY OF IMMUNIZATIONS

State Form 49445 (R4 / 4-12)

HISTORY OF IMMUNIZATIONS (indicate month and year)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
* Rotavirus (RGE)			

	1	2	or Chicken Pox Disease	Month / year
Varicella (Varivax)				

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
* HEPA		

	1	2	3
HBV (HEP B)			

* Not required but highly recommended.

Name of physician / nurse practitioner completing form (please print)	Telephone number ()
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Signature of physician / nurse practitioner

Name of child	Date of birth (month, day, year)	Age
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Name of child care facility	County
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ADDITIONAL NOTES AND INSTRUCTIONS
