FORM N-2

Stockbridge-Munsee Community | Electa Quinney Head Start
CHILD HEALTH RECORD-IMMUNIZATION RECORD

Child's Full Name **Date of Birth**

Date

Vaccine	Date Given	Dr/Clinic	Date Next Dose Due
DTP			
Dose 1			
Dose 2			
Dose 3			
Dose 4			
Dose 5			
Td			
DT			
Polio - OPV			
Dose 1			
Dose 2			
Dose 3			
Dose 4			
MMR			
Dose 1			
Dose 2			
HIB Please Specify HBOC, OMP, or PRP-D			
Dose 1			
Dose 2			
Dose 3			
Dose 4			
HB (At Birth)			
HGIB (At Birth)			
Other			
Please Specify			

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Exemptions

If a Child Cannot or Should Not Receive a Particular Immunization, Please Indicate One of the Following Reasons in Dr/Clinic Text Box Above.

1. **Has Had Disease** ☐
   ***Attach Physician's Note**
   For Rubella, only a Serologic Test is a Valid Exemption

2. **Allergy** ☐
   ***Attach Physician's Note Specifying Allergy**

3. **Parent(s) Will Not Consent** ☐
   ***Attach Parent Consent Form**

SIGNATURE

Physician's Signature **Date**