

IF YOU ARE ATTENDING DAY CAMP AT THE LOCATIONS LISTED BELOW*, PLEASE COMPLETE THE FOLLOWING PAGE ALONG WITH YOUR REGISTRATION.

**Delaware Trail Elementary
Indiana School for the Deaf
Jordan YMCA
Paramount School of Excellence
Ransburg YMCA
Westlake Elementary**

***Other sites may be accepting CCDF vouchers as well, please check with your YMCA when registering.**

IMPORTANT:

If you are completing this prior to the end of the school year and your school has a certified school nurse, he/she can be considered the health care provider and can sign the form. Your child's shot record must also be attached to the completed form.

THIS IS A REQUIRED FORM

Day Care Provider Name _____

Child Immunization Record

Child's Name _____ Date of Birth _____

Parent's Name _____ Phone _____

Address _____
Street Address City State Zip

Record Date of Immunization

	1	2	3	4	5
Hep B					
DtaP / DTP / Td					
Hib					
MMR					
IPV					
Varicella					
PCV / Prevnar					

Child has documented history of Varicella Disease _____ No _____ Yes If yes, age _____

Please check the appropriate response.

- Child has received complete age-appropriate immunizations.
- Child is currently in the process of receiving complete age-appropriate immunizations.

ONE BOX ABOVE MUST BE CHECKED BY THE HEALTH CARE PROVIDER

Comments: *(Please list immunizations excluded for medical reasons)* _____

Parent comments: *(Please indicate religious objection, if any)*

Signature _____ Date _____
(Health Care Provider's Signature and Date is **Required**.)

Printed Name and Title _____
(Printed Name and Title is **Required**)

This form must be updated annually.