

ANNUAL FAMILY DAY CARE HOME IMMUNIZATION SURVEY

For Office Use Only

LIST OF CHILDREN LESS THAN 5 YEARS OLD

Please complete this form and return in enclosed envelope
to: Immunization Branch, Department of Health Services
2151 Berkeley Way, Rm 712, Berkeley, CA 94704

COUNTY: _____

NAME: _____

ADDRESS: _____

CITY: _____

ZIP: _____

PHONE: _____

Date this form filled out: _____
(Very Important!)

Have you ever had immunization training? YES:
NO:

If you do not provide childcare at this time, please check this box:

FULL/PART-TIME CHILDREN		ENTER DATE OF EACH VACCINE RECEIVED (Month/Day/Year)															Is Child	
Child's First Name or Child's Initials	Date of Birth	Polio Doses			DTP/DTaP/DT Doses				MMR	Hib Doses				Hepatitis B Doses			Varicella	Up-to-Date (yes/no)
		1	2	3	1	2	3	4	1	1	2	3	4	1	2	3	1	
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2.																		
3.																		
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