



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Jersey Shore Branch YMCA SACC Registration Packet

Please complete the forms in this packet and return it to the Jersey Shore Branch YMCA front desk. For your registration packet to be complete items in the registration check list must be complete.

Child's Name: _____
Age: _____ Grade : _____ Gender: _____ Birthdate: _____
School: _____

Parent/Guardian Name: _____ Birthdate: _____

Address: _____

Cell Phone: _____

Email: _____

Emergency Contact: _____ Emergency Contact Cell Phone: _____

I give the YMCA School Age Staff permission to apply sunscreen on my child when the UV is 3 or above.

Parent Signature: _____

I gave the YMCA School Age Staff permission to apply lotion for chapped lips or skin on my child.

Parent Signature: _____

I give my child permission to watch a PG movie when at the YMCA program.

Parent Signature: _____

Registration Check list:

- _____ Completed emergency contact page. (ALL boxes must be filled in or marked N/A)
- _____ Completed fee agreement & automatic withdraw paper if that is the payment method.
- _____ Photo & Video release form.
- _____ Child Health Report or proof of upcoming appointment.
- _____ Income eligibility form
- _____ Download the Brightwheel app and know your 4 digit code

Are you interested in Summer Camp 2027?

- _____ Yes
- _____ I need more information
- _____ Not at this time

Are you interested in morning care before school?

- _____ Yes
- _____ I need more information
- _____ Not at this time

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3290.181 & .182

CHILD'S NAME		DATE OF BIRTH
ADDRESS		
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER ()
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME		
ADDRESS		
TELEPHONE NUMBER WHEN CHILD IS IN CARE		
PERSON(S) TO WHOM CHILD MAY BE RELEASED		
NAME		
ADDRESS		
TELEPHONE NUMBER WHEN CHILD IS IN CARE		
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		
TELEPHONE NUMBER		
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST-AID PROCEDURES
WALKS AND TRIPS		SWIMMING
TRANSPORTATION BY THE FACILITY		WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

WHITE COPY (Original)

YELLOW COPY (Child Care Space)

PINK COPY (Excursion)



YMCA CHILD CARE/School Aged Child Care Fee Agreement

My child, _____ will attend Jersey Shore YMCA Child Care Program at _____ (SITE). I, _____ agree to pay the established fee(s) listed on the fee agreement. I understand that failure to pay the fee by the due date will result in suspension or termination from care.

Please select the type of care below that _____ will receive beginning _____ by CIRCLING/ HIGHLIGHTING the appropriate rate plan.

Care Type:	
Before AND AFTER	\$110
Before OR After	\$90

Please INITIAL in the spaces below to indicate that you have read, understand, and agree to the following statements:

Initial	Policies and Statements
	I understand that payments are due on MONDAYS of the week of care, regardless of full time or part time status.
	I understand that the total fee is due regardless of attendance, holidays, emergency closings, or COVID-related quarantines. Parents may not adjust their payments.
	I understand that my child's care will be suspended if my account becomes more than 2 weeks past due.
	I understand that the YMCA charges a fee for insufficient funds/returned checks in addition to what the bank may charge.
	I understand that failure to pick up my child by closing time will result in late charges at the rate of \$20.00 per child for every 15 minutes late, beginning at 6:00pm.
	I understand that this contract may be terminated by myself or by the childcare provider. The provider may terminate the contract without notice if the parent/guardian does not make timely payments or does not follow the YMCA Code of Conduct.
	I understand that any changes to my child's discontinuation of care must be submitted to the Childcare Director with two-week notice. Failure to notify the Director two weeks in advance may result in owing the full fee, regardless of my child's attendance.
	I understand that if I am having trouble paying my childcare fees, it is MY responsibility to contact the Childcare department at the YMCA.
	I understand that if I am applying for funding, I am responsible for payment of fees until funding has been granted.
	I understand that the YMCA reserves the right to close any site or program that does not maintain adequate enrollment or staffing.
	I understand that these rates are subject to change.

CCIS/Subsidy Families ONLY:

	I understand that my co-pay is due WEEKLY on Mondays and I am responsible for keeping my account up-to-date. My copay will not change unless the YMCA is notified by the ELRC.
	I understand that if I lose funding, I am responsible for the full childcare fee (listed above).
	I understand that if my account becomes delinquent (more than 1 week past due), the YMCA is required to report the delinquency to the ELRC.
	I understand that I am responsible for paying for any "unpaid absences" or days not authorized by the ELRC.

Please INITIAL your preferred payment method for the fees listed above, and/or your established ELRC copay:

_____ I will pay by check, cash, or money order on MONDAYS each week.

_____ I will use **automatic withdrawal payments** with the information on the attached sheet.

By signing this document, I agree that I am the primary account holder and I am responsible for making payments.

Print name: _____ Signature: _____ Date: _____

Office use only: Approved by: _____ Date: _____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$	PER MIN-HR	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN

DATE



RIVER VALLEY REGIONAL YMCA CHILDCARE AUTOMATIC FUNDS TRANSFER FORM
Authorization of EFTs or Credit Card Drafts only

AUTHORIZATION TO THE YMCA: I have given my authority to the named bank/ credit card company to honor preauthorized EFT/Charge drawn by the YMCA on my account for the child care payments as indicated below. It is understood that the YMCA's transmission of a preauthorized draft to the bank as payment becomes due shall constitute valid notice of such payment due on the named activity. When the bank honors the draft by charging my account, such draft shall constitute my receipt for the payment. Should any preauthorized draft not be honored by said bank when received by them, then it is understood that the payment will be collected electronically as well as a \$25.00 NSF service fee.

I understand that the River Valley Regional YMCA drafts will continue as long as my child is in child care with the YMCA.

Payment Amount \$_____

- ☐ I choose to utilize the EFT option for payment by direct debit from
Checking ☐ Savings account ☐

Bank Name _____

Routing/Transit Number _____

Authorized Signature _____

Name on Account _____

Account Number _____

Date _____

- ☐ I choose to utilize the automatic Credit Card Payment option for my payment
Credit Card Type Visa ☐ MasterCard ☐ Discover ☐

Account Number _____

Authorized Signature _____

Card Holder Name _____

Expiration Date _____

Date _____

Attach Voided Check Here



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FOR SOCIAL RESPONSIBILITY**

APPENDIX B

PHOTO AND VIDEO/AUDIO RECORDING RELEASE

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) , I hereby give my permission and consent, now and for all time, to YMCA of the USA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities, for publication, display, sale or exhibition thereof in promotions, advertising, education and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- ☐ Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience during said activities, I authorize, according to this Release, shall belong to YMCA of the USA and collaborating third parties. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities;
- ☐ Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities will not be subject to any obligation of confidentiality and may be shared with and used by YMCA of the USA and collaborating third parties;
- ☐ YMCA of the USA and collaborating third parties collaborating shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; and
- ☐ YMCA of the USA and collaborating third parties shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge YMCA of the USA and collaborating third parties from any and all claims in connection with the uses and reproductions, any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

Signature: _____

Date: _____

Printed Name: _____

Age: _____

Address: _____

I am the Mother/Father/Legal Guardian of (child's name). For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Mother/Father/Legal Guardian: _____

FNS USE ONLY

SOLO PARA FNS



AND JUSTICE FOR ALL



In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), age, disability, and reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, and American Sign Language) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at **(202) 720-2600** (voice and TTY) or contact USDA through the Federal Relay Service at **(800) 877-8339**.

To file a program discrimination complaint, a complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form, which can be obtained online, at www.usda.gov/sites/default/files/documents/usda-program-discrimination-complaint-form.pdf, from any USDA office, by calling **(866) 632-9992**, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

fax:
(833) 256-1665 or (202) 690-7442; or

email:
program.intake@usda.gov.

This institution is an equal opportunity provider.

Conforme a la ley federal y las políticas y regulaciones de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta institución tiene prohibido discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación de sexual), edad, discapacidad, venganza o represalia por actividades realizadas en el pasado relacionadas con los derechos civiles.

La información del programa puede estar disponible en otros idiomas además del inglés. Las personas con discapacidades que requieran medios de comunicación alternativos para obtener información sobre el programa (por ejemplo, Braille, letra agrandada, grabación de audio y lenguaje de señas americano) deben comunicarse con la agencia estatal o local responsable que administra el programa o con el TARGET Center del USDA al **(202) 720-2600** (voz y TTY) o comunicarse con el USDA a través del Servicio Federal de Transmisión de Información al **(800) 877-8339**.

Para presentar una queja por discriminación en el programa, el reclamante debe completar un formulario AD-3027, Formulario de queja por discriminación del programa del USDA, que se puede obtener en línea, en [https://www.usda.gov/sites/default/files/documents/USDAProgramComplaintForm-Spanish-Section 508 Compliant.pdf](https://www.usda.gov/sites/default/files/documents/USDAProgramComplaintForm-Spanish-Section%20508%20Compliant.pdf), en cualquier oficina del USDA, llamando al **(866) 632-9992**, o escribiendo una carta dirigida al USDA. La carta debe contener el nombre, la dirección y el número de teléfono del reclamante, y una descripción escrita de la supuesta acción discriminatoria con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR, por sus siglas en inglés) sobre la naturaleza y la fecha de la presunta violación de los derechos civiles. La carta o el formulario AD-3027 completado debe enviarse al USDA por medio de:

correo postal:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; o´

fax:
(833) 256-1665 o´ (202) 690-7442; o´

correo electrónico:
program.intake@usda.gov.

Esta institución ofrece igualdad de oportunidades.

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care
receives support
from the Child and
Adult Care Food
Program to serve
healthy meals to your children.



**Meals served here must meet USDA's
nutrition standards.**

Questions? Concerns?

*[Here is space for the State agency and sponsoring organization to add
contact information]*

Learn more about CACFP at USDA's website:

<https://www.fns.usda.gov/>

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

Complete one application per household. Please use a pen (not a pencil).

Insert URL Here

Definition of Household Member : "Anyone who is living with you and shares income and expenses, even if not related." Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals.	Child's First Name	MI	Child's Last Name	Check all that apply				
	Foster Child	Migrant	Runaway	Homeless	Head Start			
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐

Write only one case number in this space.

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

Print Name of Adult Signing the Form	Signature of Adult	Today's Date
Address	City	State Zip Phone/Email

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	A friend or extended family member regularly gives a child spending money
Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) - Allowances for off-base housing, food, and clothing	- Unemployment benefits - Workers compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veterans benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private Pensions or disability benefits - Income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL

Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT

For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often?

Weekly

Bi-Weekly

Monthly

2x Month

Household size

Categorial Eligibility

☐

Eligibility

Free

Reduced

Denied

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Date:

Dear Parent(s)/Guardian(s):

Enrollment Date:

State and Agency policies require enrolled children to have a current health assessment in their file by their start date.

Your child must have a current physical on file no later than 60 days from enrollment, or care will be suspended. A copy of your physical is also acceptable, as long as it includes all vaccinations.

Please make an appointment or turn in a copy of the most recent exam as soon as possible in order to keep our records up to date. Physicals must include the following:

Results of a physical examination
Physician's signature
Immunization records

Physicals can be emailed to me at alissac@rvrymca.org or mailed to the JERSEY SHORE BRANCH YMCA. If you contact your doctor's office to have them email/mail to us, PLEASE DO NOT ASSUME THAT THEY HAVE PROCESSED YOUR REQUEST. Please make a follow up call to the Main Office to verify that it has been received.

Thank you,

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.						
HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): ☐ NONE						
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. ☐ NONE						
CHILD'S ALLERGIES (DESCRIBE, IF ANY): ☐ NONE						
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. ☐ NONE						
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? ☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:						
HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO			NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.			
			VISION (subjective until age 3)			
			HEARING (subjective until age 4)			
			LEAD			
RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD						
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						
MEDICAL CARE PROVIDER:				SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT		
ADDRESS:						
		PHONE:		LICENSE NUMBER:		DATE FORM SIGNED: