

EDITORIAL NOTE: If the child received immunizations in another part of the world, the immunizations may have been differently constituted.

RECORD OF IMMUNIZATIONS

CHILD'S NAME: _____ DATE OF BIRTH: _____
 MOTHER'S NAME: _____ INTERVIEWER ID#: _____
 ADDRESS: _____

For the child named above, please enter the administration dates for each dose of the immunizations listed that he or she received. Use the COMMENTS column to explain any discrepancies, omissions, or to supply relevant detailed information. For example, sometimes children do not receive full doses; this should be noted in the COMMENTS column.

IMMUNIZATION	DATES ADMINISTERED					COMMENTS
	DOSE 1 MO/DY/YR	DOSE 2 MO/DY/YR	DOSE 3 MO/DY/YR	DOSE 4 MO/DY/YR	DOSE 5 MO/DY/YR	
DTP (diphtheria, tetanus, pertussis)						
DT* (diphtheria, tetanus)						
Td**(tetanus, diphtheria)						
Tetanus						
OPV (oral polio)						
MMR (measles, mumps, rubella)						
HIB (haemophilus influenzae)						
Other – SPECIFY: _____						

Physician's Name

Signature of Individual Completing Form

Telephone Number

Date Form Completed

*DT - Contains the same amounts of the diphtheria and tetanus toxoids as DTP but does not contain the pertussis toxoid.

**Td - Contains the same amount of the tetanus toxoid as either DTP or DT but a reduced dose of the diphtheria toxoid.