

**Infant's Information**

Last \_\_\_\_\_ First \_\_\_\_\_ M. \_\_\_\_\_ Case Number \_\_\_\_\_

**1 Indicate information source** (Check appropriate box)

- Biological Mother/Father   
  Grandmother/Father   
  Adoptive or Foster Parents   
  Physician   
  Health Records  
 Other Specify: \_\_\_\_\_

**2 Has the infant ever received immunizations or shots?**

- Yes   
  No   
 ⇨ STOP

**Please list all of the immunizations the infant has ever been given or attach record.**

	Date given			Comments/Reactions:
	Month	Day	Year	
Hepatitis B #1 .....	___	/	___/___	_____
Hepatitis B #2 .....	___	/	___/___	_____
Hepatitis B #3 .....	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #1 (DPT) .....	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #2 (DPT) .....	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #3 (DPT) .....	___	/	___/___	_____
Haemophilus Influenzae Type b #1 (Hib) .....	___	/	___/___	_____
Haemophilus Influenzae Type b #2 (Hib) .....	___	/	___/___	_____
Haemophilus Influenzae Type b #3 (Hib) .....	___	/	___/___	_____
Inactivated Poliovirus #1 (Polio).....	___	/	___/___	_____
Inactivated Poliovirus #2 (Polio).....	___	/	___/___	_____
Inactivated Poliovirus #3 (Polio).....	___	/	___/___	_____
Measles, Mumps, Rubella (MMR) .....	___	/	___/___	_____
Varicella (Chicken Pox).....	___	/	___/___	_____
Pneumococcal .....	___	/	___/___	_____
Influenza (Flu).....	___	/	___/___	_____
Hepatitis A #1 .....	___	/	___/___	_____
Hepatitis A #2 .....	___	/	___/___	_____
Other/Specify:.....	___	/	___/___	_____

**3 Are the immunizations up to date?**     Yes     No     Unknown

Section completed on \_\_\_/\_\_\_/\_\_\_ at \_\_\_:\_\_\_ by \_\_\_\_\_

How conducted:     In person     Telephone     Other \_\_\_\_\_

