

CHILD'S NAME _____ BLOOD TYPE +/- _____

DATE OF BIRTH _____ ALLERGIES _____

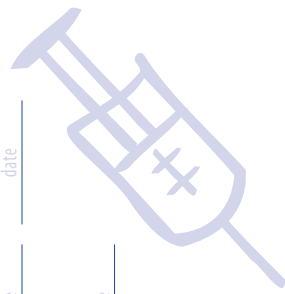
DOCTOR VISITS				
Date	Doctor Seen	Type of Visit	Parent Notes	Doctors Orders
		<input type="checkbox"/> well-baby visit <input type="checkbox"/> illness or injury <input type="checkbox"/>		
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		<input type="checkbox"/> well-baby visit <input type="checkbox"/> illness or injury <input type="checkbox"/>		

GROWTH CHART						
Date	Age	Weight	Length	Head Circumference	Percentile	
					height %	weight %
birth						
					height %	weight %
					height %	weight %
					height %	weight %
					height %	weight %
					height %	weight %
					height %	weight %
					height %	weight %
					height %	weight %

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CHILD'S NAME _____ FROM _____ TO _____ DATE DATE DATE

VACCINE	DATE & TYPE OF VACCINE GIVEN									
	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose
Hepatitis B	date									
Diphtheria, Tetanus, Pertussis (DTaP)	date	date	date	date	date	date	date	date	date	date
H. Influenza type B (Hib)	date	date	date	date	date	date	date	date	date	date
Polio (IPV)	date	date	date	date	date	date	date	date	date	date
Pneumococcal (PCV)	date	date	date	date	date	date	date	date	date	date
Rotavirus	date	date	date	date	date	date	date	date	date	date
MMR/V - Measles, Mumps, Rubella/Varicella	date	date	date	date	date	date	date	date	date	date
Other										
Other										



HEALTH RECORD
IMMUNIZATION TRACKER

For reference only. Please check with your doctor for the immunization schedule needed for your child.