

IMMUNIZATION INFORMATION



Dear Parent/Guardian;

VCH must have a record of each child's immunization history. If one of the diseases listed below occurs in your school/childcare facility and immunizations are not complete, the Medical Health Officer may require your child to stay at home. Please complete and return this form to the school/childcare facility.

Return of completed form is my consent for my child's immunization history to be entered into a Vancouver Coastal Health (VCH) confidential electronic database. If you do not wish to have this information recorded in an electronic database, please inform us in writing.

PLEASE PRINT CLEARLY School/Childcare Facility _____

Child's name _____
Surname Given Name Preferred Name

Sex: M F Birthdate / / dd mm yyyy Place of birth _____

Child's personal health number (Care Card) _____

Home address _____ Postal code _____ Home phone _____

Father's Name _____ Daytime phone _____
Surname Given Name

Mother's Name _____ Daytime phone _____
Surname Given Name

Guardian's Name _____ Daytime phone _____
Surname Given Name

Doctor's name _____ Doctor's phone _____

My child had chicken pox. Yes No Don't know.

Attach a photocopy of your child's immunization record OR fill out the following record.

IMMUNIZATION	DATES GIVEN							
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
DIPHTHERIA								
PERTUSSIS (WHOOPING COUGH)								
TETANUS								
POLIO								
HAEMOPHILUS INFLUENZAE TYPE B (HIB)								
MMR (MEASLES, MUMPS, RUBELLA)								
MEASLES (RUBEOLA)								
RUBELLA (GERMAN MEASLES)								
MUMPS								
HEPATITIS B								
MENINGOCOCCAL CONJUGATE								
PNEUMOCOCCAL CONJUGATE								
VARICELLA (CHICKENPOX)								
LIST OTHER VACCINES								