



ChildCare

Immunization Assessment

1Facility
Information**FACILITY INFORMATION**

Facility Name: _____

Facility Number: _____

Type: ☐ private ☐ public ☐ headstart

County: _____

Administer/Principal: _____

Facility Email: _____

Physical Address: _____

2Contact
Information**DESIGNATED FACILITY CONTACT**

Name: _____

Email: _____

Phone Number: _____

3Summary
Report**FACILITY STAFF MEMBER COMPLETING THIS FORM**

Name: _____

Email: _____

Phone Number: _____

Report Submitted Date: _____

Total number of Children:

Report on ages 2-5 years

UNCONDITIONAL ADMISSION:**Requirements Met**

All required immunizations

A

Requirements Met, But Missing Doses

Personal Belief Exemption

E

Pre 2016

Permanent Medical Exemption

C

IEP Services

F1

CONDITIONAL ADMISSION, NEED FOLLOW-UP:

Conditional Entrant

B

Not including Temporary Medical Exemptions

Temporary Medical Exemption

D

REQUIREMENTS NOT MET, MISSING DOSES

Overdue

G

*Previously Known as Enrolled But Not Attending***Missing Doses By Vaccine** Students are missing doses.Please indicate the total number of students
missing each vaccine:

Polio

Hep B

DTP

Varicella

MMR

Hib

TOTAL