EPI – ITR FORM

G _____ P _____
Vit. A _____

TT1 _____
TT2 _____
TT3 _____
TT4 _____
TT5 _____

Family Number: _____ 4P's: _____ NHTS: _____
Date:_____ Parent's Philhealth # _____

I. General Data:

Name of Child:_____ Birthday: _____
Complete Address: _____
Sex: _____ Time of Delivery: _____ Place of Delivery:_____
Name of Mother: _____ Age: ___ Mother's Birthday:_____
Name of Father: _____ Age: ___ Contact No:_____

II. Birth History:

Mode of Delivery: _____ Birth weight: _____ Birth length: _____
Head Circumference: _____ Chest Circumference: _____ Abdomen Circumference: _____
Newborn Screening: (Y/N) Date done: _____ Vitamin K: Date Given _____
Newborn Hearing Test: (Y/N) Date done: _____ Type of Feeding: ☐ EBF ☐ BO ☐ MF ☐ CF

III. Immunization Record:

EPI NUMBER: _____ UFC Number: _____

ANTIGEN	1	2	3	9 mos.	1 y.o
BCG					
Hepa B1 at birth					
Hepa B1>24hrs					
PentaHib					
OPV					
PCV					
IPV					
MMR1					
Vitamin A.					
MMR 2					

OTHER VACCINES GIVEN:

ANTIGEN	1	2	3

REMARKS: _____

_____

IV. Upon First Visit:

_____

Date: _____ Age in Months:_____
Initial Vital Signs: Temp: _____ Height in cm.: _____ Weight in kg: _____
Waist: _____ RR:_____/minute

Nutritional Status: ☐ Normal ☐ Underweight ☐ Severely under Weight ☐ Over Weight
☐ Wasted ☐ Severely Wasted

☐ Stunted ☐ Severely Stunted