



Missouri Department Of Health And Senior Services  
 Section for Child Care Regulation  
**Child Immunization History**

**IDENTIFYING INFORMATION**

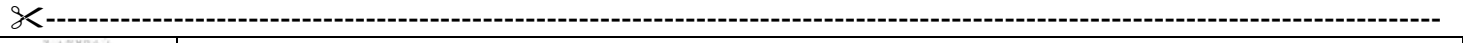
CHILD'S NAME	BIRTHDATE
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**IMMUNIZATION HISTORY**

	DATES GIVEN (Month, Day, Year)					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
DPT/DT/DTaP						
Polio						
Hepatitis B						
Hib						
MMR						
Varicella (chicken pox) –OR previous disease documentation from parent or medical source						

**NAME OF HEALTH CARE PROVIDER FOR THE ABOVE IMMUNIZATION:**

*This form can be used in lieu of a copy of the documentation from the Health Care provider.*



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