

**PRESCHOOL IMMUNIZATION HISTORY FORM**

**PLEASE COMPLETE AND RETURN THIS FORM TO THE SCHOOL/CENTRE PROMPTLY TO COMPLETE YOUR REGISTRATION PROCEDURE**

In order to protect the health of your child and the pre- school population, all parents or guardians of children seeking admission to any Licensed Childcare Facility in the jurisdiction of North or West Vancouver must provide a statement of their child's immunization. This form **MUST** be returned to the facility.

**Please be advised that all information provided will be entered into the BC Public Health Information System (database). This allows Vancouver Coastal Health to access the level of immunization within the entire preschool population and allows for quick and easy access of information should there be a communicable disease outbreak.**

**New Child to this facility: Fill out Part A and B**

**Returning Child to this facility: Fill out Part A only: Part B if new immunizations need to be added to the child's existing record.**

**Child Care Facility** \_\_\_\_\_

<b>A. CHILDS INFORMATION</b> (Please Print)	
Child's Name _____	Sex F____M____ (Birthdate ____/____/____)
Personal Health Number _____	Country of Birth _____
Parent /Guardian's Name _____	Work Phone (Father _____ (Mother) _____)
Address _____	Postal Code _____ Home Phone _____
Doctors Name _____	Doctor's Phone _____

**PLEASE SEE OTHER SIDE FOR**  
 Conscientious Objector Yes

**BASIC IMMUNIZATION SCHEDULE**

Children not protected may be excluded from the childcare centre for the duration of a communicable disease outbreak

<b>B. VACCINE AND DESCRIPTION</b>				
<b>PRIMARY INFANT SERIES</b>	<b>Dose #1</b>	<b>Dose #2</b>	<b>Dose #3</b>	<b>Dose #4</b>
1. <b>PENTACEL</b> * (DaPT/IPV/HIB)- Diphtheria, Pertussis, Tetanus, Polio & Haemophilus Influenza Type B)				
2. <b>HEPATITIS B</b>				
3. <b>PNEUMOCOCCAL CONJUGATE</b> (Pevnar)* # of doses depends upon age of start up				
4. <b>MMR</b> – combined (Measles, Mumps and Rubella)				
5. <b>MENINGOCOCCAL C CONJUGATE</b> # of doses depends upon age of start up				
6. <b>VARICELLA</b> (Chicken Pox or history of disease)				
7. <b>OTHER (SPECIFY)</b>				
<b>SCHOOL ENTRY</b>				
<b>QUADRACEL</b> (DaPT/IPV) –school entry booster of Diphtheria/pertussis/Tetanus/Polio)				
<b>OTHER (SPECIFY)</b>				

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ROUTINE IMMUNIZATION SCHEDULE

		2 mo	4 mo	6 mo	12 mo	18 mo	4- 6 yr	Gr 6	Gr 9	Adult
<b>DaPT/IPV/HIB</b> (Diphtheria, Pertussis, Tetanus, Polio, Haemophilus Influenza type B)	Diphtheria	•	•	•		•	•		•	•♥
	Pertussis	•	•	•		•	•		•	•
	Tetanus	•	•	•		•	•		•	•♥
	Polio	•	•	•		•	•			
	Haemophilus Influenza type B	•	•	•		•				
PNEUMOCOCCAL CONJUGATE <sup>1</sup>	•	•	•		•					
HEPATITIS B <sub>2</sub>	•	•	•					•♦		
MMR (Measles, Mumps, Rubella) <sub>3</sub>	Measles				•	•				
	Mumps				•	•				
	Rubella				•	•				
MENINGOCOCCAL C <sub>4</sub> Conjugate				•				•♦		
VARICELLA <sub>5</sub> CHICKENPOX				•						

♥Adults require Diphtheria and Tetanus every 10 years.

1. Pneumococcal Conjugate Program is for all infants born on or after July 1, 2003.

2. **Hepatitis B Infant Program is for all infants born on or after July 1, 1998. All other children are immunized for Hepatitis B in Grade 6 (♦2 dose schedule as of September 2001).**

3. **2 doses on or after the 1<sup>st</sup> birthday NO EXCEPTIONS**

4. Meningococcal C Conjugate Program is for all infants born on or after July 1, 2002.

♦All other children are immunized for Meningococcal C in Grade 6 (as of Sept. 2003).

5. Varicella is recommended but not publicly funded.

**IMMUNIZATION CLINICS**  
**CALL 604-983-6863 FOR APPOINTMENT**