

Infant's Information

Last _____ First _____ M. _____ Case Number _____

1 Indicate information source (Check appropriate box)

- Biological Mother/Father
 Grandmother/Father
 Adoptive or Foster Parents
 Physician
 Health Records
 Other Specify: _____

2 Has the infant ever received immunizations or shots?

- Yes
 No
 ⇨ STOP

Please list all of the immunizations the infant has ever been given or attach record.

	Date given			Comments/Reactions:
	Month	Day	Year	
Hepatitis B #1	___	/	___/___	_____
Hepatitis B #2	___	/	___/___	_____
Hepatitis B #3	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #1 (DPT)	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #2 (DPT)	___	/	___/___	_____
Diphtheria, Tetanus, Pertussis #3 (DPT)	___	/	___/___	_____
Haemophilus Influenzae Type b #1 (Hib)	___	/	___/___	_____
Haemophilus Influenzae Type b #2 (Hib)	___	/	___/___	_____
Haemophilus Influenzae Type b #3 (Hib)	___	/	___/___	_____
Inactivated Poliovirus #1 (Polio).....	___	/	___/___	_____
Inactivated Poliovirus #2 (Polio).....	___	/	___/___	_____
Inactivated Poliovirus #3 (Polio).....	___	/	___/___	_____
Measles, Mumps, Rubella (MMR)	___	/	___/___	_____
Varicella (Chicken Pox).....	___	/	___/___	_____
Pneumococcal	___	/	___/___	_____
Influenza (Flu).....	___	/	___/___	_____
Hepatitis A #1	___	/	___/___	_____
Hepatitis A #2	___	/	___/___	_____
Other/Specify:.....	___	/	___/___	_____

3 Are the immunizations up to date? Yes No Unknown

Section completed on ___/___/___ at ___:___ by _____

How conducted: In person Telephone Other _____

