Department of Health & Human Services
DHHS
NEBRASKA

Division of Public Health - Licensure Unit - Children's Services Licensing Program

Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name:_____ Birthdate(s):_____

Enrollment Date:_____ Updates:_____ Date Care Ceased: _____

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

MOTHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____ (Caregiver)

to contact Doctor _____ (Name of Physician) _____ (Phone)

_____ (Address) _____ (City) and, if necessary, take my child(ren) to the

following doctor(s), clinics, or hospital _____

_____ (Signature of Parent/Guardian) _____ (Date)

MEDICATION COMPETENCY STATEMENT

I, _____ (Parent /Guardian Name) have determined

that _____ (Provider/Director/Staff Name(s)) is/are competent to give or apply medication to my child(ren).

_____ (Signature of Parent/Guardian) _____ (Date)

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____

Medication, if any: _____

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____

Special Concerns: (Glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

_____ (Signature of Parent/Guardian) _____ (Date)

Department of Health & Human Services
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Nebraska Department of Health and Human Services
IMMUNIZATION RECORD

Child(s) Name:

Birthdate(s): | Enrollment Date:

REQUIRED IMMUNIZATIONS

Vaccine	Type of Vaccine	Dose	Normal Schedule	Date Given Mo	Day	Yr	Doctor or Clinic Administering
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6 - 18 mo.				
		4	4 - 6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15 - 18 mo.				
		5	4 - 6 yrs.				
Tdap		1	11 - 18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12 - 15 mo.				
M-M-R		1	12 - 15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox date of disease		1	12 - 18 mo.				
		2					
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12 - 15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian:_____ Date:_____

I do not wish to have (child's name)_____immunized. The reason for the decision is:

_____

Signature of Parent/Guardian:_____ Date:_____