Little Stars
early learning center, LLC
300 Madison Ave, Mankato, MN 56001

CHILD CARE IMMUNIZATION FORM

This form documents your child's immunization history and any reasons why specific immunizations were not administered. Minnesota law requires children enrolled in child care to be immunized against certain diseases or to have a legal medical or conscientious exemption on file. This form must be on file before a child attends child care.

You may attach a copy of the child's immunization history to this form OR enter the month, day, & year for all vaccines your child received. If a vaccine was not administered select MED (medically contra-indicated due to a history of disease or laboratory evidence of immunity) or CO (vaccines that are contrary to parent/gauardian conscientious beliefs).

Sign or obtain appropriate signatures on next page. Complete section 1A or 1B to certify immunization status. Complete section 2A for medical exemptions (including varicella disease) and 2B for conscientious exemptions.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970

Child Last Name:	Child First Name:	Date of Birth (mm/dd/yyyy):	Date of Enrollment (mm/dd/yyyy):

TYPE OF VACCINE	1st DOSE (mm/dd/yyyy)	2nd DOSE (mm/dd/yyyy)	3rd DOSE (mm/dd/yyyy)	4th DOSE (mm/dd/yyyy)	5th DOSE (mm/dd/yyyy)
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) - 3 doses during 1st year (at 2 month intervals) - 4th dose at 12-18 months - 5th dose at 4-6 years (Not required if 4th dose given after 4th birthd					
Polio (IPV or OPV) - 2 doses during 1st - 3rd dose at 12-18 months - 4th dose at 4-6 years (Not required if 4th dose given after 4th birthday					
Measles, Mumps, and Rubella (MMR) - Required for children 15 months and older - 1st dose on or after 1st birthday - 2nd dose at 4-6 years		Not Required			
Haemophilus influenzae type b (Hib) - 2-3 doses in the first year - 1 dose required after 12 months or older - For unvaccinated children 15-59 months, 1 dose is required - Not required for children 5 years or older				Not Required	
Varicella (chickenpox) - Required for children 15 months and older - 1st dose on or after 1st birthday - 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) - Required for children age 2 - 24 months - 3 doses in the first year - 4th dose after 12 months - At least 1 dose recommended for children 24-59 mos in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) - 2 doses separated by 6 months for children 12 months and older					
Rotavirus (Recommended) - (2-3 doses between 2 and 6 months)	Not Required	Not Required	Not Required		
Influenza (Recommended) - (annually for children 6 months or older)	Not Required	Not Required	Not Required	Not Required	Not Required

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CHILD CARE IMMUNIZATION FORM
(Continued)

1. Certify Immunization Status (Complete section 1A or 1B to indicate child's immunization status)

1A. Children who are 15 months or older

For children who are 15 months or older and who have received all the immunizations required by law for child care:

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic:

Date (mm/dd/yyyy):

1B. Children who are younger than 15 months

For children who are younger than 15 months OR have not received all required immunizations:

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic:

Date (mm/dd/yyyy):

2. Exemptions to Immunization Law (Complete section 2A and/or 2B to indicate type of exemption)

2A. Medical Exemption

No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

Signature of Physician / Nurse Practitioner / Physician Assistant :

Date (mm/dd/yyyy):

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in year _____

Signature of Physician / Nurse Practitioner / Physician Assistant (If disease occurred before September 2010, a parent/guardian can sign)

Date (mm/dd/yyyy):

2B. Conscientious Exemption

No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify, by notarization, that it is contrary to my conscientiously held beliefs for my child to receive the following checked vaccine(s):

- ☐ Diphtheria, Tetanus, & Pertussis (DTaP, DTP)
- ☐ Polio (IPV, OPV)
- ☐ Measles, Mumps, & Rubella (MMR)
- ☐ Haemophilus Influenzae Type b (Hib)
- ☐ Varicella (Chickenpox)
- ☐ Pneumococcal Conjugate Vaccine (PCV)
- ☐ Hepatitis B (Hep B)
- ☐ Hepatitis A (Hep A
- ☐ Rotavirus
- ☐ Influenza

Signature of Parent / Guardian:

Date (mm/dd/yyyy):

Subscribed and Sworn to before me this:

_____day of _____20_____

_____

Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

When you are finished click the "SUBMIT" button to the right. You will be notified of errors requiring correction. You can save the form and finish it later. When the form has passed all checks it will be locked from further changes. You will be able to save it to your computer and print copies for signature/submission and records.

SUBMIT