



**Children's Circle of Second Presbyterian Church**

7700 North Meridian Street  
Indianapolis, Indiana 46260  
(317) 252-5517  
Fax #: (317) 252-5590

**Child's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Child lives with** \_\_\_\_\_ **Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**HISTORY OF IMMUNIZATIONS**

(Indicate Month/Day/Year)

\_\_\_\_\_ **Polio** 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

\_\_\_\_\_ **DTaP/DT/Td** 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

\_\_\_\_\_ **MMR** 1) \_\_\_\_\_ 2) \_\_\_\_\_

\_\_\_\_\_ **Hib vaccine** 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

\_\_\_\_\_ **Prenvar/Pneumococcal Conjugate/PCV7**  
1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

\_\_\_\_\_ **Varicella (Chicken Pox)**  
1) \_\_\_\_\_ or Written Statement of History \_\_\_\_\_

**NOTE:** To be considered adequately immunized a child of age twenty-four months should have received four DTP inoculations, three oral polio feedings, one inoculation against measles, mumps, and rubella, at least three HIB vaccinations, four Prenvar inoculations, and one Varicella inoculation.

**Allergies:** (Please be specific!)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Physician Completing Form: \_\_\_\_\_ Phone # \_\_\_\_\_  
(Please Print)

Physicians Signature \_\_\_\_\_