CDC/SGH# 1907

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Email:	**Telephone Number:**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Email:	**Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Relationship:**	**Telephone Number:**
Name:	**Relationship:**	**Telephone Number:**
Name:	**Relationship:**	**Telephone Number:**
Name:	**Relationship:**	**Telephone Number:**

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to: **www.azdhs.gov/phs/immun/index.htm** or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction oc ur ::	☐ **No** ☐ **Yes**
Is child usually susceptible to infections and if so, what precautions need to be taken? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Is child subject to convulsions and what should be our procedure if one occurs? **If yes**, specify procedure:	☐ **No** ☐ **Yes**
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Other special instructions:	
My child has been screened for: Please circle all that apply Hearing Eye exam Speech Developmental Delays Other: _____	
Please list outcomes of the above screenings:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**