

Group Family Day Care Immunization Survey

GROUP FAMILY DAY CARE ID# _____

GROUP FAMILY DAY CARE NAME: _____

GROUP FAMILY DAY CARE ADDRESS: _____

If the pre-printed information above is incorrect, please print the correct name and/or address here:

Has this facility been closed (permanently or temporarily)? _____

Due Date: September 15

New York State Public Health Law Section 2164 requires that this form be completed. Instructions for completing the survey are located in the survey packet.

CHILDREN LESS THAN 1 YEAR OF AGE

- 1 Total number of children
- 2 Children without immunization record
- 3 Medical Exemption
- 4 Religious Exemption
- 5 Diphtheria, Tetanus and Pertussis (DTaP)
- 6 Polio
- 7 Haemophilus influenzae type b
- 8 Hepatitis B
- 9 Pneumococcal
- 10 Completely Immunized
- 11 In Process

CHILDREN 1 YEAR OF AGE AND OLDER

- 1 Total number of children
- 2 Children without immunization record
- 3 Medical Exemption
- 4 Religious Exemption
- 5 Diphtheria, Tetanus and Pertussis (DTaP)
- 6 Polio
- 7 Measles, Mumps and Rubella (MMR)
- 8 Haemophilus influenzae type b
- 9 Hepatitis B
- 10 Varicella
- 11 Pneumococcal
- 12 Completely Immunized
- 13 In Process

Contact Person for the Facility: _____ Home or Cell Phone #: _____

Email Address: _____ Fax #: _____

I certify that the data is complete and accurate to the best of my knowledge.

Facility Owner or Administrator Name: _____

Owner or Administrator Signature: _____ Date: _____