OMB #: 0925-0593

OMB Expiration Date: 08/31/2014

Infant and Child Health Care Log

*Birth to 6 years old*

BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL STUDY TELEPHONE CALLS AND VISITS.



**Save all bottles and containers of medications. Bring to Study visits and have available for telephone calls:**

* Medicines (those prescribed by a health care provider and those bought over-the-counter)
  + Vitamins, minerals, herbs, and any other supplements

Child’s Last Name Child’s First Name Child’s Date of Birth: / /

mm dd yyyy

Public reporting for this collection of information is estimated to average 5 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974,ATTN: PRA (0925-0593). Do not return the completed form to this address.

Infant and Child Health Care Log

This Infant and Child Health Care Log will help you keep track of all your child’s visits to doctors or other health care providers from birth to 6 years old. We will ask you about your child’s visits whenever we interview you by telephone or in person.

**A Health Care Provider can be:**

* Pediatrician or family medicine doctor
* Specialist (like a surgeon, heart doctor, allergy or skin doctor)
* Nurse practitioner or physician assistant
* Nurse
* Social worker/counselor
* Other

**Health Care Visits can be to:**

* Doctor’s office, clinic, or health center
* Emergency room
* Urgent care center
* Hospital (inpatient, overnight stay)
* Some other place The log has two parts:

1. **Health Care Provider Log** is to record information about where your child visits the doctor or other health care provider.
2. **Health Care Visit Log** is to record information about all of your child’s visits to doctors, other health care providers, or an emergency room. This includes overnight hospital stays as well as outpatient visits.

**BRING** this Infant and Child Health Care Log with you to all of your child’s health care and National Children’s Study visits. Also, have it available for all National Children’s Study telephone interviews.

If you forget to bring it with you to a health care visit, please fill it in as soon as possible.

**Save all bottles and containers of medications and bring to National Children’s Study visits and have available for telephone calls:**

* Medicines (those prescribed by a health care provider and those bought over-the-counter)
* Vitamins, minerals, herbs, and any other supplements

**Health Care Provider Log Instructions**

*The health care provider is the person who cared for your child at this visit (doctor, nurse, social worker, etc.)*

#### **Column 1** A number is listed for each health care provider (For example, 1, 2, 3, 4, etc.). This number will be referred to on the Health Care Visit Log pages.

**Column 2** Attach the health care provider’s business card here.

**Fill in columns 3–10 only if you have not attached the health care provider’s business card.**

**Column 3** Write in the name of the health care provider.

**Column 4** Check (✓) the box for the type of provider. If it was “Other,” write the type of health care provider.

**Column 5** Check (✓) the box for the type of place where you saw the provider. If it was “Other place,” write in the type of place where your child visited the health care provider.

**Columns 6–9** Write in the address of the place including city/town, state, and ZIP code.

**Column 10** Write in the telephone number of the health care provider including area code.

*See the example in the first line of the log on the next page.*

**After you fill out the Health Care Provider Log, please fill out the Health Care Visit Log.**

**Inform the National Children’s Study staff when more log pages are needed.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | *Fill in ONLY if you HAVE NOT attached a business card* | | | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Health Care Provider Number** | **Attach Health Care Provider Business Card** | **Name of Health Care Provider/Clinic/Hospital** | **Type of Health Care Provider** | **Type of Place** | **Street Address** | **City or Town** | **State** | **ZIP**  **Code** | **Telephone Number** |
| **0** | **EXAM** | Dr. Joe Jones  **PLE** | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): | 400Main Street | Capitol City | MN | 56087 | 937-889-  9275 |
| **1** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **2** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **3** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |

# Health Care Provider Log

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | *Fill in ONLY if you HAVE NOT attached a business card* | | | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Health Care Provider Number** | **Attach Health Care Provider Business Card** | **Name of Health Care Provider/Clinic/Hospital** | **Type of Health Care Provider** | **Type of Place** | **Street Address** | **City or Town** | **State** | **ZIP**  **Code** | **Telephone Number** |
| **4** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **5** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **6** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **7** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |

# Health Care Provider Log

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | *Fill in ONLY if you HAVE NOT attached a business card* | | | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Health Care Provider Number** | **Attach Health Care Provider Business Card** | **Name of Health Care Provider/Clinic/Hospital** | **Type of Health Care Provider** | **Type of Place** | **Street Address** | **City or Town** | **State** | **ZIP**  **Code** | **Telephone Number** |
| **8** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **9** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **10** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |
| **11** |  |  | * Pediatrician or family physician * Specialist * Nurse   practitioner  or physician assistant   * Nurse * Social worker/   counselor   * Other (specify): | * Doctor’s office, clinic, or health center * Emergency   room   * Urgent care   center   * Hospital * Other place   (specify): |  |  |  |  |  |

# Health Care Provider Log

Infant and Child Health Care Log

**Health Care Visit Log Instructions**

***Office and Outpatient Visits and Overnight Hospital Stays***

*Each time your child goes to the doctor or any other health care provider (For example, doctor, nurse, social worker, etc.) or is hospitalized overnight, write down information about the visit on a new line in the Health Care Visit Log.*

*Please try to fill in columns 1–3 before the visit. If possible, ask your health care provider or the office staff to fill out columns 4–10. If that is not possible, please fill out columns 4–10 at the visit or as soon as possible.*

**Column 1**

**Column 2**

**Column 3**

**Column 4–6**

**Column 7**

**Column 8**

**Column 9**

**Column 10**

Health care visit date (month/day/year).

Write the Health Care Provider number from Column 1 in the Health Care Provider Log.

Check (✓) the reason(s) for the visit and explain if needed. Include office/outpatient visits and overnight hospital stays. *For example:*

If your child got a well-baby check up, put a check (✓) in the “Routine well visit” box.

Write in your child’s weight, and length or height at the visit. Write in the Head Circumference through age 2. If these measurements were not done, check (✓) “Not done.” *For example:* If your child is 22 inches long at his visit, write in “22” inches.

If your child got an immunization/vaccination/shot during the visit, put a check (✓) in the “YES” box and **Go to the Immunization/ Vaccination/Shot Log**.

If your child gets any test, medication, or treatment during his/her visit, write it here.

Write what the health care provider told you (the diagnosis) at the visit. Include a few key words to describe the event or diagnosis. *For example:* For a check-up or well child visit, the doctor may have told you that your child is “growing normally and is healthy” or “has an ear infection.” Write this down in the “Diagnosis or Problem” column.

Check (✓) the box to show if the office staff filled out the log or if you did. After you report the visit to the National Children’s Study staff, please write in the date you told us about that visit.



*See the example in the first line of the log on the next page.*

**Inform the National Children’s Study staff when more log pages are needed.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Date of Visit** | **Health Care Provider Number from Health Care Provider Log** | **Reason for Visit (check all that apply)** | **Weight** | **Length/ Height** | **Head Circumference (0–2 years)** | **Immunization/ Vaccination/ Shot** | **Tests/Medications/ Treatments**  (For example, lab tests (blood, urine…), medicines, vitamins, minerals, herbs, supplements, procedures) | **Diagnosis or Problem** | **Completed by Office or Self** |
| **Date Reported to National Children’s Study** |
| March 3, 2011 | 0 | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | 10 *lb*  *pounds*  4 *oz*  *ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | 23 *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | 37 *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log**  **EXA** | Lab test (blood)  **PLE** | Well infant,  good growth and development | * Office * Self |
| Date:  March 4, 2011 |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb*  *pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in*  *inches*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |

**M**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Date of Visit** | **Health Care Provider Number from Health Care Provider Log** | **Reason for Visit (check all that apply)** | **Weight** | **Length/ Height** | **Head Circumference (0–2 years)** | **Immunization/ Vaccination/ Shot** | **Tests/Medications/ Treatments**  (For example, lab tests (blood, urine…), medicines, vitamins, minerals, herbs, supplements, procedures) | **Diagnosis or Problem** | **Completed by Office or Self** |
| **Date Reported to National Children’s Study** |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb*  *pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Date of Visit** | **Health Care Provider Number from Health Care Provider Log** | **Reason for Visit (check all that apply)** | **Weight** | **Length/ Height** | **Head Circumference (0–2 years)** | **Immunization/ Vaccination/ Shot** | **Tests/Medications/ Treatments**  (For example, lab tests (blood, urine…), medicines, vitamins, minerals, herbs, supplements, procedures) | **Diagnosis or Problem** | **Completed by Office or Self** |
| **Date Reported to National Children’s Study** |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb*  *pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Date of Visit** | **Health Care Provider Number from Health Care Provider Log** | **Reason for Visit (check all that apply)** | **Weight** | **Length/ Height** | **Head Circumference (0–2 years)** | **Immunization/ Vaccination/ Shot** | **Tests/Medications/ Treatments**  (For example, lab tests (blood, urine…), medicines, vitamins, minerals, herbs, supplements, procedures) | **Diagnosis or Problem** | **Completed by Office or Self** |
| **Date Reported to National Children’s Study** |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |
|  |  | * Routine well visit * Sick visit * Specialist doctor visit * Emergency visit * Immunization/vaccination/   shot   * Follow-up visit * **Overnight hospital stay**   How many nights?   * Some other reason (explain): | *lb*  *pounds*  *oz ounces*  *OR*  *kg kilograms*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | *in*  *inches*  *OR*  *cm centimeters*   * Not done/ don’t know | * No * Yes   **If ‘YES’ then go to Immunization/ Vaccination/ Shot Log** |  |  | * Office * Self |
| Date: |

Infant and Child Health Care Log



**Immunization/Vaccination/Shot Log Instructions**

* + Write in the date of the immunization/vaccination/shot.
  + Put a check (✓) in the box of each vaccine(s) given to your child. Ask your child’s health care provider to help you to check all of the right boxes.
  + At the bottom of the log, write in if your child had any problems after any of the immunizations, vaccinations, or shots.

*See the example in the first line of the log on the next page.*

Contact your child’s doctor if your child has any problems after an immunization/vaccination/shot.

Immunization/Vaccination/Shot Log

**Needles or Injections Needles or Injections**

**By Nasal**

**Combination Vaccines**

Measles, Mumps, Rubella, and Varicella (MMRV)

**Combination Vaccines**

**Mouth Needle**

**Mist**

DATE OF IMMUNIZATION

Hepatitis B (Hep B)

Diphtheria, Tetanus, and Pertussis (whooping cough) (DTaP)

H. Influenza Type B (Hib)

Inactivated Polio (IPV)

Pneumococcal Conjugate (PCV7)

DTaP, Hep B, and IPV

Hib and Hep B

DTaP and Hib

DTaP and IPV

DTaP, IPV, and Hib

Varicella (Chickenpox)

Hepatitis A

Meningococcal

1. Palivizumab to prevent RSV (Respiratory Syncytial Virus)

Rotavirus

Influenza (Seasonal “Flu”)

Influenza (Seasonal “Flu”)

Other

March 3, 2011

**EXAMPLE**

Measles, Mumps, and Rubella (MMR)

XYZ Vaccine

|  |  |  |
| --- | --- | --- |
| **ANY PROBLEMS AFTER A IMMUNIZATION/VACCINATION/SHOT?** | | |
| **Date of the Immunization/Vaccination/Shot** | **Date You First Noticed the Problem** | **Describe the Problem** |
|  |  |  |
|  |  |  |
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Immunization/Vaccination/Shot Log

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Needles or Injections** | | | | | | | | | **Needles or Injections** | | | | | | | **By Mouth** | **Needle** | **Nasal Mist** |  |
|  | | | | | **Combination Vaccines** | | | | **Combination Vaccines** | | |  |  |  |  |
| DATE OF IMMUNIZATION | Hepatitis B (Hep B) | Diphtheria, Tetanus, and Pertussis (whooping cough) (DTaP) | H. Influenza Type B (Hib) | Inactivated Polio (IPV) | Pneumococcal Conjugate (PCV7) | Measles, Mumps, and Rubella (MMR) | Measles, Mumps, Rubella, and Varicella (MMRV) | DTaP, Hep B, and IPV | Hib and Hep B | DTaP and Hib | DTaP and IPV | DTaP, IPV, and Hib | Varicella (Chickenpox) | Hepatitis A | Meningococcal | 1. Palivizumab to prevent RSV (Respiratory Syncytial Virus) | Rotavirus | Influenza (Seasonal “Flu”) | Influenza (Seasonal “Flu”) | Other |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |
| --- | --- | --- |
| **ANY PROBLEMS AFTER A IMMUNIZATION/VACCINATION/SHOT?** | | |
| **Date of the Immunization/Vaccination/Shot** | **Date You First Noticed the Problem** | **Describe the Problem** |
|  |  |  |
|  |  |  |
|  |  |  |

Immunization/Vaccination/Shot Log

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Needles or Injections** | | | | | | | | | **Needles or Injections** | | | | | | | **By Mouth** | **Needle** | **Nasal Mist** |  |
|  | | | | | **Combination Vaccines** | | | | **Combination Vaccines** | | |  |  |  |  |
| DATE OF IMMUNIZATION | Hepatitis B (Hep B) | Diphtheria, Tetanus, and Pertussis (whooping cough) (DTaP) | H. Influenza Type B (Hib) | Inactivated Polio (IPV) | Pneumococcal Conjugate (PCV7) | Measles, Mumps, and Rubella (MMR) | Measles, Mumps, Rubella, and Varicella (MMRV) | DTaP, Hep B, and IPV | Hib and Hep B | DTaP and Hib | DTaP and IPV | DTaP, IPV, and Hib | Varicella (Chickenpox) | Hepatitis A | Meningococcal | 1. Palivizumab to prevent RSV (Respiratory Syncytial Virus) | Rotavirus | Influenza (Seasonal “Flu”) | Influenza (Seasonal “Flu”) | Other |
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| **ANY PROBLEMS AFTER A IMMUNIZATION/VACCINATION/SHOT?** | | |
| **Date of the Immunization/Vaccination/Shot** | **Date You First Noticed the Problem** | **Describe the Problem** |
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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

National Institutes of Health

Centers for Disease Control and Prevention

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