



# IMMUNIZATION VERIFICATION

**Please note:** This form may be used by the applicant/recipient to provide information necessary to establish eligibility. The following information may be provided in another form or statement.

**Case Name:** \_\_\_\_\_ **Case Number:** \_\_\_\_\_

**In order to determine the public assistance eligibility for the following children, verification of immunizations is required. Please assist us by answering the questions below and returning this form to our office by \_\_\_\_\_.**

\_\_\_\_\_  
Economic Self-Sufficiency Specialist's Signature

\_\_\_\_\_  
Date

DCF Mailing Address:

**(Economic Self-Sufficiency Specialist: Complete name and DOB of all children under 5 years old)**

Name Of Child	Date Of Birth	Are Immunizations Current?	If Yes, Date Next Immunizations Due?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**If the immunizations are not current on any of the above children, please answer the following questions.**

Is there a medical reason for delaying the immunization(s)?  Yes  No

Please list which child(ren) has the medical condition, and the date the medical exemption will end.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
End Date

\_\_\_\_\_  
Signature of Doctor or Authorized Designee

\_\_\_\_\_  
Date