

Parent-Child Assistance Program (PCAP)

TC Medications and Immunizations

Client ID: _____

T/C DOB: _____

Vaccine/ Due	Dose	Completed
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Hepatitis B (Hep B)

Birth	1	
1-2 mos.	2	
6-18 mos.	3	

Rotavirus (RV1, RV5)

2 Mos.	1	
4 mos.	2	
6 mos.	3	

Diphtheria, Tetanus, Pertussis (DTAP, DTP, DT)

2 mos.	1	
4 mos.	2	
6 mos.	3	
15-18 mos.	4	
4-6 yrs.	5	

Haemophilus influenzae type b (HIB)

2 mos.	1	
4 mos.	2	
6 mos.	3	
12-15 mos.	4	

Pneumococcal (PCV, PPSV)

2 mos.	1	
4 mos.	2	
6 mos.	3	
12-15 mos.	4	

Vaccine/ Due	Dose	Completed
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Polio (IPV, OPV)

2 mos.	1	
4 mos.	2	
6-18 mos.	3	
4-6 yrs.	4	

Infuenza (yearly)

6 mos.	1	
7 mos.	2	
1.5 yrs.	2	
2.5 yrs.	3	
3.5 yrs.	4	

Measles, Mumps, Rubella (MMR)

12-15 mos.	1	
4-6 yrs.	2	

Varicella (chickenpox)

6-15 mos.	1	
4-6 yrs.	2	

Hepatitis A (Hep A)

12-23 mos.	1	
6-18 mos. later	2	

Review every six months with Biannual data:

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Date	Status	Initial
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Date	Status	Initial
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Date	Status	Initial
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Parent-Child Assistance Program (PCAP)

Allergies/Special Diet (List allergy information here - type, special instructions etc.)

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Medications

Medication name/dosage:	Date:
Prescribing Dr./phone:	
Special instructions:	

Medication name/dosage:	Date:
Prescribing Dr./phone:	
Special instructions:	

Well Child Exam Schedule

Infants: Birth	Toddlers: 12 months
3 to 5 days	15 months
1 months	18 months
2 months	24 months
4 months	30 months
6 months	3 years
9 months	Childhood: Yearly until age 21