Adoption Center of Illinois
at Family Resource Center

PHYSICIAN'S STATEMENT OF IMMUNIZATION STATUS

(For Adoption Home Study Purposes)

Child's Full Name: _____

Date of Birth: _____

I hereby confirm that I am the licensed healthcare provider responsible for the care of the above-named child. Based on my medical records and knowledge of the child's health history, I attest to the following:

☐ The child is up to date on all immunizations as recommended by the **American Academy of Pediatrics (AAP)** immunization schedule.

Notes:

☐ The child is not currently up to date on immunizations. Please explain below, including any medical contraindications or plans for catch-up vaccinations:

Notes:

Healthcare Provider Information

Provider's Name (Print): _____

Medical License Number: _____

Signature of Provider: _____

Date: _____