Ministry of Health and Medical Education

Health Department

Community Nutrition Improvement Office

**Child Care Card**

(Nutrition, Vaccination, Growth Monitoring)

Special for Boys

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| --- | --- |
| File No.:Child’s Name and Surname:Mother’s Name:Father’s Name:Date of Birth:  | Weight at Birth (gr): Height at Birth (cm): Head Circumference (cm): Child Birth Order: Time interval between the birth of the child and the last alive child of the mother (month): Type of Delivery: Natural 🗌 Cesarean 🗌Multifetal 🗌 Term 🗌 Preterm 🗌 |
| Province: ---- County: ---- Village: ---Medical Center: ---- Private Clinic: ---Outreach Team: ---- Health Center: --- Home Address: ---- Home Tel: ---- Others: ----  |
| * Please bring the Child Care Card with yourself at any visit to the health center or private clinic.
* Exclusive breastfeeding is necessary for the natural growth of the infant till the end of the first six month, and continuing it till the end of the second year.
* Ensure your child’s health by on-time vaccination.
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| **Vaccination Guide Table** | **Age**  | **Type of Vaccine** | **Age**  | **Type of Vaccine** |
| At birth | BCG, Polio, Hepatitis B | 6 months | OPV, Pentavalent, IPV |
| 2 months | OPV, Pentavalent  | 12 months | Measles, Mumps and Rubella (MMR) |
| 4 months | OPV, Pentavalent, IPV | 18 months | Triple, OPV, MMR |
| 6 years | Triple, OPV |
| **Remarks:** **\*** PentavalentVaccine includes Diphtheria, Tetanus, Pertussis, Hepatitis B and Haemophilus Influenzae Type B (Hib). \* After the last dose of Triple Vaccine, all adults should get a booster dose of TD (Tetanus-Diphtheria) every 10 years |
| **Notes:** * Vaccinate your children according to the guideline against the diseases of Tuberculosis, Polio, Hepatitis B, Diphtheria, Tetanus, Pertussis, Measles, Mumps, and Rubella.
* A cold or diarrhea does not prevent you from on-time vaccination.
* Before leaving the health center, please ask about the next vaccination date.
* Stay at the vaccination center at least 15 minutes after receiving the vaccine.
* To soothe the pain, discomfort, or fever, ask the necessary guidelines from the vaccinator.
* Attend the health center in case of high fever or any other severe complication.
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| **Type of Vaccine** | **Date** | **Vaccinator’s Seal** | **Type of Vaccine** | **Date** | **Vaccinator’s Seal** |
| BCG |  |  | Pentavalent Vaccine(DTP – Hep.B- Hib) | 1st Dose |  |  |
| Oral Polio Vaccine (OPT) | At Birth |  |  | 2nd Dose |  |  |
| 1st Dose |  |  | 3rd Dose |  |  |
| 2nd Dose |  |  | Triple or simultaneous child vaccine (DTP/ DT) | 1st Dose |  |  |
| 3rd Dose |  |  | 2nd Dose |  |  |
| 1st Booster |  |  | Measles, Mumps and Rubella (MMR) | 1st Dose |  |  |
| 2nd Booster | - |  | 2nd Dose |  |  |
| Inactivated Polio Vaccine (IPV) |  |  | Hepatitis B (Hep.B) | At Birth |  |  |
| **Remarks:**  |

Signed and sealed by

True translation from the Persian original, hereto appended, is certified.

Official translator to the Judiciary