Baby's Name:

Date of Birth:

Place of Birth:

Delivery Method (Vaginal / C-section):

BABY MEDICINES

AZT (Zidovudine) Dose:

AZT Start Date:

Other Medicines:

MY BABY'S DOCTOR/CLINIC

Doctor/Clinic Name:

Street Address:

City, State, ZIP code:

Phone:

APPOINTMENTS

Date:	Time:	am/pm
Date:	Time:	am/pm
Date:	Time:	am/pm
Date:	Time:	am/pm

TEST RESULTS

Date:	Result #1:
Date:	Result #2:
Date:	Result #3:
Date:	Result #4:

ISSUES, CONCERNS, PROBLEMS