

# CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_ Date of Birth:     /     /     Sex:   **M**   **F**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type	
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		<b>Rotavirus</b>	1		
	2			2		
	3			3		
	4		<b>Measles, Mumps, Rubella</b> (MMR, MMRV)	1		
1		2				
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	2		<b>Varicella</b> (Var, MMRV)	1		
	3			2		
	4		<b>Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)</b>	1		
	5			2		
	6			<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1	
	7				2	
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1			3		
	2			4		
	3			5		
	4			6		
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1		
	2			2		
	3		<b>Hepatitis A</b> (HepA, HepA-HepB)	1		
	4			2		
	5			<b>Human Papillomavirus</b> (HPV)	1	
1		2				
<b>Pneumococcal Conjugate</b> (PCV7)	2			3		
	3		<b>Other:</b>			
	4					

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

*I certify that this immunization information was transferred from the above-named individual's medical records.*

**Doctor or nurse's name (please print):** \_\_\_\_\_ **Date:**     /     /

**Signature:** \_\_\_\_\_

**Facility name:** \_\_\_\_\_