

# CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_

Date of Birth:     /     /

Sex:   M   F

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> (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2				2		
	3				3		
	4			<b>Measles, Mumps, Rubella</b> (e.g., MMR, MMRV)	1		
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1				2		
	2			<b>Varicella</b> (e.g., Var, MMRV)	1		
	3				2		
	4			<b>Meningococcal Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)</b>	1		
	5				2		
	6			<b>Seasonal Influenza Inactivated</b> IIV3, IIV4, cclIV3-IM, IIV3-ID, IIV3-HD RIV3-IM <u>Live Attenuated</u> LAIV, LAIV4	1		
	7				2		
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				3		
	2			4			
	3			<b>2009 H1N1 Influenza</b> Inactivated or Live	1		
	4				2		
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			<b>Pneumococcal Polysaccharide (PPSV23)</b>	1		
	2				2		
	3			<b>Hepatitis A</b> (e.g., HepA, HepA-HepB)	1		
	4				2		
	5				<b>Human Papillomavirus</b> (HPV4, HPV2)	1	
<b>Pneumococcal Conjugate</b> (PCV7, PCV13)	1			2			
	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:** \_\_\_\_\_