

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

Check the box if this person has a physician-certified reliable history of Chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of Chickenpox
- physical diagnosis of Chickenpox, or
- serologic proof of immunity

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