

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

| 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"> 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: _____