

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		Seasonal Influenza Inactivated IIV3, IIV4, cclIV3-IM, IIV3-ID, IIV3-HD	1	
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1		RIV3-IM	3	
	2		Live Attenuated LAIV, LAIV4	4	
	3		2009 H1N1 Influenza Inactivated or Live	1	
	4			2	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		Pneumococcal Polysaccharide (PPSV23)	1	
	2			2	
	3		Hepatitis A (e.g., HepA, HepA-HepB)	1	
	4			2	
	5		Human Papillomavirus (HPV4, HPV2)	1	
Pneumococcal Conjugate (PCV7, PCV13)	1			2	
	2			3	
	3		Other:		
	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"> 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: _____