

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: _____