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

☐ 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: