

# 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	
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			<b>Measles, Mumps, Rubella</b> (e.g., MMR, MMRV)	1			
	2				2			
	3			<b>Varicella</b> (Var, MMRV)	1			
	4				2			
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			<b>Meningococcal Quadrivalent</b> MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1			
	2				2			
	3			<b>Meningococcal Serogroup B (Men B)</b> MenB-FHbp MenB-4C	1			
	4				2			
	5				3			
	6			<b>Seasonal Influenza</b> Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, cclIV3-IM	1			
	7				2			
	8				3			
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1			Live Attenuated LAIV, LAIV4 (quadrivalent)	4			
	2				5			
	3				6			
	4				7			
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1				<b>2009 H1N1 Influenza</b> Inactivated or Live	1		
	2					2		
	3				<b>Pneumococcal Polysaccharide</b> (PPSV23)	1		
	4			2				
	5			<b>Hepatitis A</b> (HepA, HepA-HepB)		1		
			2					
<b>Pneumococcal Conjugate</b> (PCV13, PCV7)	1			<b>Human Papillomavirus</b> (9vHPV, 4vHPV, 2vHPV)	1			
	2				2			
	3				3			
	4							
<b>Rotavirus</b> (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			<b>Zoster (shingles)</b>	1			
	2			<b>Other:</b>	1			
	3				2			

Please see next page ➡

# CERTIFICATE OF IMMUNIZATION (continued)

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"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>	

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