# 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 | | **Seasonal 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 | | **H1N1 Influenza** Inactivated (Intramuscular) or Live (Intranasal) | 1 | |
| | 4 | | | 2 | |
| **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:**