CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Sex: M F**

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B series (e.g., HepB, HepB-Hib,DTaP-HepB-IPV,HepA-HepB)	1		
	2		
	3		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT,DTaP-Hib,DTaP-HepB-IPVDTaP-IPV/Hib,DTaP-IPV,Td,Tdap) **within last 10 years**	1		
MMR	1		
	2		
Varicella or documented proof of disease	1		
PPD within last year	1		

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: _____