

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			Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2				2		
	3			Varicella (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM	1		
	7				2		
	8				3		
Haemophilus influenzae type 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		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			2009 H1N1 Influenza Inactivated or Live	1		
	2				2		
	3			Pneumococcal Polysaccharide (PPSV23)	1		
	4				2		
	5				Hepatitis A (HepA, HepA-HepB)	1	
			2				
Pneumococcal Conjugate (PCV13, PCV7)	1			Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1		
	2				2		
	3				3		
	4						
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			Zoster (shingles)	1		
	2			Other:	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"> • 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: _____