##### CERTIFICATE OF IMMUNIZATION

# 

# **Name:** **Date of Birth: / / Gender:**

### Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** |  | Date | Vaccine Type | Vaccine |  | Date | Vaccine Type |
| Hepatitis B(e.g., HepB, Hep B-CpG, 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 |  |  | MeningococcalQuadrivalentMenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4) | 1 |  |  |
| 2 |  |  | 2 |  |  |
| 3 |  |  | **Meningococcal**  **Serogroup B (Men B)** MenB-FHbp (Trumenba)MenB-4C (Bexsero) | 1 |  |  |
| 4 |  |  | 2 |  |  |
| 5 |  |  | 3 |  |  |
| 6 |  |  | Seasonal InfluenzaInactivated(e.g., IIV4, RIV4, ccIIV4, IIV3, IIV3-HD, aIIV3, RIV3, IIV4-ID)Live Attenuated(e.g., LAIV, LAIV4) | 1 |  |  |
| 7 |  |  | 2 |  |  |
| 8 |  |  | 3 |  |  |
| *Haemophilus influenzae* type b(e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY) | 1 |  |  | 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 |  |  |
| **Pneumococcal Conjugate** (PCV13, PCV7) | 1 |  |  | 2 |  |  |
| 2 |  |  | **Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV) | 1 |  |  |
| 3  1 |  |  | 2 |  |  |
| 4 |  |  | 3 |  |  |
| **Rotavirus** (e.g., RV5: 3-dose series, RV1: 2-dose series) | 1 |  |  | **Zoster** (Shingles)  (RZV [Shingrix],  ZVL [Zostavax]) | 1 |  |  |
| 2 |  |  | 2 |  |  |
| 3 |  |  | 3 |  |  |

**Please see next page**

##### CERTIFICATE OF IMMUNIZATION (continued)

### Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

**Other Vaccines:**

|  |  |  |
| --- | --- | --- |
| **Vaccine Type** | **Dose No.** | **Date** |
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| --- | --- | --- | --- | --- | --- |
| **Serologic Evidence of Immunity** | | Check One | |  | Chickenpox History |
| Test (if done) | Date of Test | Positive | Negative |  | 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 evidence of immunity |
| Measles | / / |  |  |  |
| Mumps | / / |  |  |  |
| Rubella | / / |  |  |  |
| Varicella\* | / / |  |  |  |
| Hepatitis B | / / |  |  |  |
| \* Must also check Chickenpox History box. | | | |  |

*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:**