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 Live Attenuated LAIV, LAIV4 (quadrivalent)	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				2		
	4				3		
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

☐ 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: