CERTIFICATE OF IMMUNIZATION

This Record must be completed by school and childcare center personnel from an immunization record provided by the parent or guardian.

Student Name.. Sex: M.... F....

Birth Date................................ Place of Birth..

Name of Parent or Guardian................................. Telephone...................

VACCINE	TYPE		DATE (Month/Day/Year)	HEALTH PROVIDER	DATE NEXT DOSE DUE
DTaP DT Td (Specify Vaccine Type) (Diphtheria, Tetanus Pertusis)		1			
		2			
		3			
		4			
		5			
		6			
POLIO OPV IPV (Specify Vaccine Type)		1			
		2			
		3			
		4			
		5			
MMR (Measles, Mumps, Rubella)		1			
		2			
HIB (Haemophilus b Vaccine)		1			
		2			
		3			
		4			
HBV (Hepatitis B Vaccine)		1			
		2			
		3			
Hepatitis A		1			
		2			
		3			
Varicella		1			
		2			
PCV 7 (pneumococcal conjugate)		1			
		2			
		3			
		4			