

IMMUNIZATION CERTIFICATE

Name of Student _____ Date of Birth _____

Phone Number _____ Grade _____

For vaccines given in combination, please list each component

DTap

1	2	3	4	5
---	---	---	---	---

Tdap

--

DT or dT

1	2	3	4	5
---	---	---	---	---

IPV

1	2	3	4	5
---	---	---	---	---

HIB

1	2	3	4
---	---	---	---

PNEUMOCOCCAL VACCINE

1	2	3	4
---	---	---	---

VARICELLA

1	2
---	---

Hx of Disease

Month	Year
-------	------

MMR

1	2
---	---

MEASLES

--	--

MUMPS

--	--

RUBELLA

--	--

HEPATITIS B

1	2	3
---	---	---

MENINGOCOCCAL

1	2
---	---

 SIGNATURE OF PHYSICIAN OR CERTIFYING AUTHORITY

 DATE