CERTIFICATE OF IMMUNIZATION

______________________________ ______________________________

Name of Student **Signature of Healthcare Provider**

Diphtheria, Pertussis, Tetanus (D.P.T.)	1. _________	2. _________	3. _________
	4. _________	5. _________	6. __________ additional date
Adacel / Boostrix	1. __________	2. __________	
Diphtheria, Tetanus Vaccine	1. _________	2. _________	3. _________
IPV/OPV	1. _________	2. _________	3. _________
	4. __________	5. __________ additional date	6. __________ additional date
M.M.R. (or the following 3:)	1. _________	2. _________	
First Live Measles Vaccine given after 1 year of age	1. _________	2. _________	Titer _________
			Disease__________
First Live Mumps Vaccine given after 1 year of age	1. ________	2. _________	Titer __________
			Disease__________
First Live Rubella Vaccine given after 1 year of age	1. _________	2. _________	Titer __________
			Disease __________
Varivax (chicken pox)	1. _________	2._________	Titer _________
			Disease __________
Hib. - Given between 18 months and 5 years of age	1. _________	2. _________	3. _________
	4. __________		
Hepatitis B	1. _________	2. _________	3. _________
Hepatitis A	1. __________	2. __________	
Meningococcal	1. __________		
Other	__________	__________	__________