

**PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ Parent or Guardian \_\_\_\_\_  
 Telephone \_\_\_\_\_

Please circle present grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Other \_\_\_\_\_

VACCINE Circle appropriate item	Enter month, day and year each immunization will be given												DOSES
	1	2	3	4	5	6	7	8	9	10	11	12	
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Varicella	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Meningococcal (MCV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /
Other	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Other / /

Attach EHR of vaccines already given.

X \_\_\_\_\_  
 Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)

PLAN

