COMMONWEALTH OF KENTUCKY

IMMUNIZATION CERTIFICATE

(Required for each child enrolled in day care center, certified family child care home, other licensed facility which cares for children, preschool programs, and public and private primary and secondary schools.)

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle)

Name of Parent of Guardian: _____

Address: _____
(Street) (City) (State) (Zip code)

DATES IMMUNIZATIONS WERE ADMINISTERED (Month/Day/Year)

Diphtheria, Tetanus, Pertussis* #1___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___

Hib** #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

PCV (Pneumococcal) #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

Polio #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

Hepatitis B*** #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ or **Adult dose:** #1 ___/___/___ #2 ___/___/___

MMR (Measles, Mumps, Rubella) #1 ___/___/___ #2 ___/___/___

Varicella #1 ___/___/___ #2 ___/___/___ **or child has had chickenpox or zoster disease (X)** ____

Tdap #1 ___/___/___ **or Td** #1 ___/___/___ **Meningococcal** #1 ___/___/___

*DTaP, DTP, or DT. **Hib not required at 5 years of age or more. ***Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age.

This child is current for immunizations until ___/___/___, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, or nurse designee) (Date)

_____
(Name of Office or Licensed Healthcare Facility)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky UNBRIDLED SPIRIT

EPID-230 (Rev 08/2010)