

# Certificate of Immunization

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

| Vaccine                                                         | Vaccine Type | Date Given | Source |
|-----------------------------------------------------------------|--------------|------------|--------|
| Diphtheria,<br>Tetanus,<br>Pertussis<br>DTaP/DTP/<br>DT/Td/Tdap |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
| Polio<br>IPV/OPV                                                |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
| Measles,<br>Rubella<br>MMR                                      |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
| Haemophilus<br>influenzae<br>type b<br>Hib                      |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |
|                                                                 |              |            |        |

| Vaccine                  | Vaccine Type | Date Given | Source |
|--------------------------|--------------|------------|--------|
| Hepatitis B<br>Hep B     |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
| Varicella*<br>Chickenpox |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
| Pneumococcal<br>PCV      |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
| Meningococcal<br>MenACWY |              |            |        |
|                          |              |            |        |
|                          |              |            |        |
|                          |              |            |        |

\* If patient has a history of natural disease, write "Immune to Varicella".

I certify the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Name (Print): \_\_\_\_\_  
 Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: \_\_\_\_\_  
 Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Date: \_\_\_\_\_