IDPH

Iowa Department of Public Health

Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

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

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Sour
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			