Massachusetts Department of Public Health CERTIFICATE OF IMMUNIZATION

| Date of Birth: | 1 | 1 | | Sex: | □ fe | emale | □ r | male |
|--|--------------|--------------------|-------------------|---|---|------------|----------|----------------------|
| If com | bination v | accine is adn | ninistered, plo | ease indicate vaccine ty | /pe (e | .g., DTa | P-Hib, | etc.) |
| accine | | Date/Vacc | ine Type | Vaccine | | | Date/\ | /accine Type |
| Hepatitis B e.g., HepB, HepB-Hib, DTaP-HepB-IPV) | 1 | | | Haemophilus | 1 | | | |
| | 2 | | | influenzae type b (e.g., Hib, HepB-Hib, | 2 | | | |
| | 3 | | | DTaP-Hib) | 3 | | | |
| Diphtheria, | 1 | | | | 4 | | | |
| etanus, Pertussis | | | | Measles, Mumps, | | | | |
| .g., DTaP, DT, | 2 | | | Rubella | 1 | | | |
| DTaP-Hib, DTaP-HepB-IPV, Td) | 3 | | | (MMR) | 2 | | | |
| | 4 | | | Varicella | 1 | | | |
| | 5 | | | (Var) | 2 | | | |
| | 6 | | | Hepatitis A | 1 | | | |
| | 7 | | | (HepA) | 2 | | | |
| Polio | | | | Pneumococcal | 1 | | | |
| e.g., IPV, DTaP-HepB-IPV) | 1 | | | - Polysaccharide | | | | |
| | 2 | | | (PPV23) | 2 | | | |
| | 3 | | | Influenza Inactivated | 1 | | | |
| | 4 | | | (Intramuscular) or | 2 | | | |
| neumococcal | 1 | | | Live (Intranasal) | 3 | | | |
| Conjugate PCV7) | 2 | | | Other: | | | | |
| | 3 | | | | | | | |
| | 4 | | | | | | | |
| | 4 | | | | | | | |
| Serologic | Proof | | | | Chick | kenpox F | listory | |
| of Immunity | | Chec | k One | | | | | |
| Test (if done) | Date of Test | Positive | Negative | Check the box | if this p | erson has | a physic | ian-certified reliab |
| Measles | / / | | | history of chickenpox. Reliable history may be based on: | | | | |
| Mumps | / / | | | | | | | |
| Rubella | / / | | | physician interpreta | hysician interpretation of parent/guardian description of | | | |
| Varicella* | / / | | | chickenpox | | | | |
| Hepatitis B | / / | | | physical diagnosis of chickenpox, or serologic proof of immunity | | | | |
| * Must als | so check Chi | ckenpox History bo | DX. | serologic proof of in | imunity | | | |
| I certify that this in | nmunizatior | n information was | s transferred fro | m the above-named individ | ual's m | nedical re | cords. | |
| Doctor or nurse | e's name (| (please print) | | Date: | | 1 | 1 | |

Certificate of Immunization June 2004