Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name____

Date of Birth_______________________________**Sex (check off) Female**______**Male**_____

VACCINE				DATE		VACCINE		DATE
Hepatitis B			**1**			**Hib**	**1**	
			2				**2**	
			3				**3**	
DTaP	**DT**	**Td**	**1**				**4**	
			2			**MMR**	**1**	
			3				**2**	
			4			**Varivax**	**1**	
			5				**2**	
			6			**Hepatitis A**	**1**	
			7				**2**	
IPV			**1**			**PPV23***(Pneumococcal*	**1**	
			2			*Polysaccaride 23-valent)*	**2**	
			3			**Influenza**	**1**	
			4				**2**	
PCV7			**1**				**3**	
(Pneumococcal			**2**			**Other**		
conjugate			**3**			*Date & Results*		
7-valent)			**4**			*Of Lead Test*		

Serologic Proof Of Immunity		**Check**	**One**		**Check Off for**	**Chickenpox History**
Test (if done)	**Date of Test**	**Positive**	**Negative**			**CHECK IN THE COLUMN TO THE LEFT IF**
Measles						**THIS PERSON HAS A PHYSICIAN-CERTIFIED**
Mumps						**RELIABLE HISTORY OF CHICKENPOX.**
Rubella						Reliable history may be based on:
Varicella*						• Physician interpretation of parent/guardian description of chickenpox
Hepatitis B						• Physical diagnosis of chickenpox, or
	***Must History box**	**also check off in column**	**Chickenpox to the right**			• Serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print)_______________________________Date:___________

Signature:____

Facility name:____