# 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 |
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| **Diphtheria, Tetanus, Pertussis** DTaP/DTP/DT/ Td/Tdap | | | |
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| **Polio** IPV/OPV | | | |
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| **Measles, Mumps, Rubella** MMR | | | |
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| ***Haemophilus influenzae* type b** Hib | | | |
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| **Hepatitis B** | | | |
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| | Vaccine | Date Given | Doctor / Clinic / Source |
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| **Varicella** Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"* | | | |
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| **Pneumococcal** PCV/PPSV | | | |
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| **Meningococcal** MCV/MPSV/ Mening B | | | |
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| **Hepatitis A** | | | |
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| **Rotavirus** | | | |
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| **Human Papilloma Virus** HPV | | | |
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| **Other** | | | |
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January 2013