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, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			

Vaccine	Vaccine Type	Date Given	Source
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal 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: ____ Date: ________________

Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

July 2024