Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / **Sex:** ☐ **female** ☐ **male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- 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: