



# 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.

<b>Diphtheria, Tetanus, Pertussis</b> DTaP/DTP/DT/ Td/Tdap	Vaccine	Date Given	Doctor / Clinic / Source

<b>Polio</b> IPV/OPV	Vaccine	Date Given	Doctor / Clinic / Source

<b>Measles, Mumps, Rubella</b> MMR	Vaccine	Date Given	Doctor / Clinic / Source

<b>Haemophilus influenzae type b</b> Hib	Vaccine	Date Given	Doctor / Clinic / Source

<b>Hepatitis B</b>	Vaccine	Date Given	Doctor / Clinic / Source

<b>Varicella</b> Chicken Pox	Vaccine	Date Given	Doctor / Clinic / Source

*If applicant has a history of natural disease write "Immune to Varicella"*

<b>Pneumococcal</b> PCV/PPSV	Vaccine	Date Given	Doctor / Clinic / Source

<b>Meningococcal</b> MCV/MPSV/ Mening B	Vaccine	Date Given	Doctor / Clinic / Source

<b>Hepatitis A</b>	Vaccine	Date Given	Doctor / Clinic / Source

<b>Rotavirus</b>	Vaccine	Date Given	Doctor / Clinic / Source

<b>Human Papilloma Virus</b> HPV	Vaccine	Date Given	Doctor / Clinic / Source

<b>Other</b>	Vaccine	Date Given	Doctor / Clinic / Source

