



Iowa Department of Public Health Certificate of Immunization

Name Last: _____

Parent/Guardian: _____

First: _____

Address: _____

Middle: _____

Date of Birth: _____

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 |
|--|------------|--------------------------|
| Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap | | |
| | | |
| | | |
| | | |
| Polio IPV/OPV | | |
| | | |
| | | |
| Measles, Mumps, Rubella MMR | | |
| | | |
| | | |
| Haemophilus influenzae type b Hib | | |
| | | |
| | | |
| Hepatitis B | | |
| | | |
| | | |

| Vaccine | Date Given | Doctor / Clinic / Source |
|---|------------|--------------------------|
| Varicella Chicken Pox <i>If applicant has a history of natural disease write "immune to Varicella"</i> | | |
| | | |
| | | |
| Pneumococcal PCV/PPSV | | |
| | | |
| | | |
| Meningococcal MCV/MPSV/ Mening B | | |
| | | |
| | | |
| Hepatitis A | | |
| | | |
| | | |
| Rotavirus | | |
| | | |
| | | |
| Human Papilloma Virus HPV | | |
| | | |
| | | |
| Other | | |
| | | |
| | | |