Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / **Sex:** G**female** G**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**			**Chickenpox History**
☐ Test (if done)	Date of Test	Positive	Negative		Check the box if this person has a physician-certified reliable history of chickenpox.
Measles	/ /				Reliable history may be based on:
Mumps	/ /				• physician interpretation of parent/guardian description of chickenpox
Rubella	/ /				• physical diagnosis of chickenpox, or
Varicella*	/ /				• serologic proof of immunity
Hepatitis B	/ /				
* Must also check Chickenpox History box.					

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: