

Longwood Medical Area Child Care Center

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
	4		4
Diphtheria, Tetanus, Pertussis (e.g., DtaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1	Measles, Mumps, Rubella (MMR)	1
	2		2
	3	Varicella (Var)	1
	4		2
	5		1
	6	Hepatitis A (HepA)	2
	7		3
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	Other:	
	2		
	3	Other:	
	4		

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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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none">• 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: _____