

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
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		<b>Measles, Mumps, Rubella</b> (MMR)	1	
	2			2	
	3		<b>Varicella</b> (Var)	1	
	4			2	
	5				
	6		<b>Hepatitis A</b> (HepA)	1	
	7			2	
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1	
	2			2	
	3		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
<b>Pneumococcal Conjugate</b> (PCV7)	1		<b>Other:</b>	3	
	2				
	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
<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"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

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: \_\_\_\_\_