

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><br>(e.g., HepB, HepB-Hib, DTaP-HepB-IPV)                            | 1 |                   | <b>Haemophilus influenzae type b</b><br>(e.g., Hib, HepB-Hib, DTaP-Hib)    | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   |  | 3 |                   |
|  |   | 4                 |  |   |                   |
| <b>Diphtheria, Tetanus, Pertussis</b><br>(e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 |                   | <b>Measles, Mumps, Rubella</b><br>(MMR)                                    | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | <b>Varicella</b><br>(Var)  | 1 |                   |
|  | 4 |                   |  | 2 |                   |
|  | 5 |                   | <b>Hepatitis A</b><br>(HepA)   | 1 |                   |
|  | 6 |                   |  | 2 |                   |
|  | 7 |                   |  |   |                   |
| <b>Polio</b><br>(e.g., IPV, DTaP-HepB-IPV)   | 1 |                   | <b>Pneumococcal Polysaccharide</b><br>(PPV23)                              | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | <b>Influenza</b><br>Inactivated<br>(Intramuscular) or<br>Live (Intranasal) | 1 |                   |
|  | 4 |                   |  | 2 |                   |
| <b>Pneumococcal Conjugate</b><br>(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.<br>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: \_\_\_\_\_