

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 (MMR)</b>	1	
	2			2	
	3		<b>Varicella (Var)</b>	1	
	4			2	
	5			2	
	6		<b>Hepatitis A (HepA)</b>	1	
	7			2	
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide (PPV23)</b>	1	
	2			2	
	3		<b>Influenza Inactivated (Intramuscular) or Live (Intranasal)</b>	1	
	4			2	
<b>Pneumococcal Conjugate (PCV7)</b>	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**

Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

/ 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:** \_\_\_\_\_