Name ______________________________ Birthdate ______________________________

Address ______________________________ Parent or guardian ______________________________

______________________________ Telephone ______________________________

Race/ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic origin: ☐ Yes ☐ No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other ____________

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology	Date	Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

H502.320 Rev. 03/17