



Iowa Department of Public Health Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (____) _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis <small>DTaP/DTIP/DT/ Td/Tdap</small>			
Polio <small>IPV/OPV</small>			
Measles, Mumps, Rubella <small>MMR</small>			
Haemophilus influenzae type b <small>Hib</small>			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella <small>Chicken Pox If patient has a history of natural disease write "Immune to Varicella"</small>			
Pneumococcal <small>PCV/PPV</small>			
Meningococcal <small>MCV4/MPSV4</small>			
Hepatitis A			
Rotavirus			
Human Papilloma Virus <small>HPV</small>			
Other			