



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.

Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap	Vaccine	Date Given	Doctor / Clinic / Source

Polio IPV/OPV	Vaccine	Date Given	Doctor / Clinic / Source

Measles, Mumps, Rubella MMR	Vaccine	Date Given	Doctor / Clinic / Source

Haemophilus influenzae type b Hib	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis B	Vaccine	Date Given	Doctor / Clinic / Source

Varicella Chicken Pox	Vaccine	Date Given	Doctor / Clinic / Source

If applicant has a history of natural disease write "Immune to Varicella"

Pneumococcal PCV/PPSV	Vaccine	Date Given	Doctor / Clinic / Source

Meningococcal MCV/MPSV/ Mening B	Vaccine	Date Given	Doctor / Clinic / Source

Hepatitis A	Vaccine	Date Given	Doctor / Clinic / Source

Rotavirus	Vaccine	Date Given	Doctor / Clinic / Source

Human Papilloma Virus HPV	Vaccine	Date Given	Doctor / Clinic / Source

Other	Vaccine	Date Given	Doctor / Clinic / Source