



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		Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/Td/Tdap				Varicella Chicken Pox <i>If applicant has a history of natural disease write "Immune to Varicella"</i>			
Polio IPV/OPV				Pneumococcal PCV/PPSV			
Measles, Mumps, Rubella MMR				Meningococcal MCV/MPSV/ Mening B			
Haemophilus influenzae type b Hib				Hepatitis A			
Hepatitis B				Rotavirus			
				Human Papilloma Virus HPV			
				Other			