

IMMUNIZATION CERTIFICATE

ARCHDIOCESE OF WASHINGTON – DISTRICT OF COLUMBIA SCHOOLS

Child's Name: _____

Last
First
MI

Gender: Male: Female: Birth Date: ____/____/____

Month
Day
Year

School: _____

Parent/
Guardian Name: _____ Phone: _____

Street Address: _____ City/ST: _____ Zip: _____

RECORD OF IMMUNIZATION											
Vaccine Type						Vaccine Type					
Mark M/D/Year for each						Mark M/D/Year for each					
Dose #	DTP-DTaP	DT-Td	Polio	Hib	Hep B	PCV7	Dose #	M-M-R	Measles	Rubella	Mumps
1							1				
2							2				
3							Dose #	Varicella	Other__	Other__	Other__
4							1				
5							2				

Physician/Medical Provider:

To the best of my knowledge, the vaccines listed above were administered as indicated.

Signature: _____
Physician or Health Official

Title: _____ Date: _____

Medical Contraindication:

The above child has a valid medical contraindication to being immunized at this time.

This is a permanent condition temporary condition until ____/____/____

Indicated vaccine(s) and reasons: _____

Signature: _____ Date: _____
Physician or Health Official