



PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

Name _____ Birthdate _____ Gender _____

Parent / Guardian _____

School annual update - circle grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Other

VACCINES ADMINISTERED

Enter month, day, and year when immunization doses listed below were given.

Diphtheria, tetanus, and acellular pertussis (DTaP, DTP, Td or DT)

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Polio (OPV or IPV)

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Hepatitis B

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Measles - Mumps - Rubella (MMR)

1st _____ 2nd _____ Disease Date _____ Circle illness: Measles - Mumps – Rubella (German)

Varicella (Chicken Pox)

1st _____ 2nd _____ Disease Date _____

Meningococcal (MCV) Meningitis

1st _____ 2nd _____

Human Papillomavirus (HPV)

1st _____ 2nd _____ 3rd _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

MEDICAL EXEMPTION

The physical condition of the above-named child is such that immunization would endanger life or health.

Provider Name _____ Practice _____

Provider Signature _____ Date _____

NON-MEDICAL EXEMPTION

Please circle your reason for requesting this exemption.

RELIGIOUS

STRONG PHILOSOPHICAL / MORAL / ETHICAL CONVICTION

State your reason for requesting this exemption:

Parent / Guardian Signature _____ Date _____