



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: _____

First Name: _____

Middle Initial: _____ Birthdate (mm/dd/yyyy): _____ Sex: _____

Symbols below:
 ♦ Required for School and Child Care/Preschool
 ● Required for Child Care/Preschool Only

Parent/Guardian Name (please print): _____

Parent/Guardian Signature Required _____ Date _____

I certify that the information provided on this form is correct and verifiable.

Office Use Only

Reviewed by: _____ Date: _____

Signed Cert. of Exemption on file? Yes No

Vaccine	Dose	Date		
		Month	Day	Year
♦ Hepatitis B (Hep B)	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
♦ Rotavirus (RV1, RV5)	1			
	2			
	3			
♦ Diphtheria, Tetanus, Pertussis (DTap, DTP, DT)	1			
	2			
	3			
	4			
	5			
♦ Tetanus, Diphtheria, Pertussis (Tdap, Td)	1			
	2			
● Haemophilus influenzae type b (Hib)	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
♦ Polio (IPV, OPV)	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
♦ Measles, Mumps, Rubella (MMR)	1			
	2			
♦ Varicella (chickenpox) or verify disease 1-4	1			
	2			
Hepatitis A (Hep A)	1			
	2			
Meningococcal (MCV, MPSV)	1			
	2			
Human Papillomavirus (HPV)	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission.

Printed Staff Name _____ Date _____
Printed Staff Name _____ Date _____

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. Mark option 1, 2, 3, OR 4 below - see, back #5.

- 1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry. Must be marked by printout (not by hand) to be valid.
- 2) Chickenpox disease verified by Health Care Provider (HCP). If you choose this box, mark 2A OR 2B below.
2A) Signed note from HCP attached OR
2B) HCP signed here and print name below:

Licensed health care provider (HCP) Signature _____ Date _____ (MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry. If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*. If you choose this box, fill in the date or child's age when he or she had the disease: _____ Age/Date of disease: _____
*Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box. Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

Diphtheria Mumps Other: _____
 Hepatitis A Polio
 Hepatitis B Rubella
 Hib Tetanus
 Measles Varicella

Licensed health care provider (HCP) Signature _____ Date _____ (MD, DO, ND, PA, ARNP)
HCP Printed Name: _____