



# 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, 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
<b>Diphtheria, Tetanus, Pertussis</b> <i>DTaP/DTP/DT/Td/Tdap</i>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Polio</b> <i>IPV/OPV</i>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Measles, Mumps, Rubella</b> <i>MMR</i>			

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

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Hepatitis B</b>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Varicella</b> <small>Chicken Pox</small> <small>If applicant has a history of natural disease write "Immune to Varicella"</small>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Pneumococcal</b> <i>PCV/PPV</i>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Meningococcal</b> <i>MCV4/MPSV4</i>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Hepatitis A</b>			

	Vaccine	Date Given	Doctor / Clinic / Source
<b>Other</b>			

Licensed Child Care Requirements	
<b>2 through 5 months</b> 1 dose Diphtheria/Tetanus/Pertussis 1 dose Polio 1 dose Hib	<b>6 through 14 months</b> 2 doses Diphtheria/Tetanus/Pertussis 2 doses Polio 2 doses Hib
<b>15 through 18 months</b> 3 doses Diphtheria/Tetanus/Pertussis 3 doses Polio 3 doses Hib with final dose $\geq$ 12 months of age, or 1 dose $\geq$ 15 months of age 1 dose Measles/Rubella $\geq$ 12 months of age	<b>19 months and older</b> 3 doses Diphtheria/Tetanus/Pertussis 3 doses Polio 3 doses Hib with the final dose $\geq$ 12 months, or 1 dose $\geq$ 15 months of age 1 dose Measles/Rubella $\geq$ 12 months of age 1 dose Varicella $\geq$ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease

Elementary/Secondary School Requirements	
<b>4 years of age and older</b> 4 doses Diphtheria/Tetanus/Pertussis with 1 dose $\geq$ 4 year of age; 3 doses if born before September 15, 2000; or 4 doses if born after September 15, 2001 3 doses Polio, with 1 dose $\geq$ 4 years of age 2 doses Measles/Rubella or positive antibody test for measles and rubella. First dose $\geq$ 12 months of age; second dose no less than 28 days after the first dose 3 doses Hepatitis B if born on or after July 1, 1994 1 dose Varicella $\geq$ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease	