Certificate Of Immunization History

Name: _____ Birthday: _____/____/_____
Last First Middle Month Day Year

Country of Origin: _____

Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin)

Name:_____ Relationship to student: _____
Last First Middle

Address:_____
No. & Street City State Zip/Postal Code Country

Telephone:(_____)_____ Work/Cell:(_____)_____

To be completed and signed by a licensed health care provider. Any attached documents in a language other than English **must be translated into English** by the health care provider.

R	**Tuberculosis Screening** All students are required to complete the tuberculosis screening				
	IMMUNIZATIONS				
R	**Tetanus, diphtheria, pertussis (Tdap)** within 10 yrs	____/____/____	**OR Tetanus diphtheria (Td)** within 10 yrs	____/____/____	
	Hepatitis A	① ____/____/____	② ____/____/____		
R	**Hepatitis B or Hep A/B (Twinrix)**	① ____/___/____ ② ___/____/____	③ ___/____/____		**OR** titer indicating immunity. **Must attach lab results. OR** signed waiver
	Human Papillomavirus	① ____/____/____ ② ____/____/____	③ ____/____/____		□ Gardasil □ Cervarix
R	**Measles, mumps, rubella (MMR):** Received after first birthday **OR Measles (Rubeola)**: **Mumps:** **Rubella:**	① ____/____/____ ①___/____/____ ①___/____/____ ①___/____/____	② ____/____/____ ②___/____/____ ②___/____/____ ②___/____/____		**OR** titer(s) indicating positive immunity **Must attach lab results.**
R	**Meningococcal vaccine-**students	① ___/____/____	② ___/____/____	< 22 years of age **OR** waiver signed	□ MCV4 given □ MPS4 given
	Meningitis B	① ___/____/____	② ___/____/____	③ ___/____/____	□ Bexsero □ Trumenba
	Other Immunizations:	_____ (Name) ____/____/____		_____ (Name) ____/____/____	
		_____ (Name) ____/____/____		_____ (Name) ____/____/____	
R	**Polio IPV or OPV**	____/____/____ ____/____/____ ____/____/____ ___/____/____		**OR** titer indicating positive immunity	**Must attach lab results.**
	Varicella (Chicken Pox) strongly recommended	Date of disease: ___/____/____	**OR vaccines** ① ___/____/____ 2 doses, ≥ 1 mo. apart	② ___/____/____	**OR** titer indicating immunity. **Must attach lab results.**
R	= Required				

Hepatitis B Vaccine Waiver

I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

_____
Signature of Student or Parent/Legal Guardian Date

Meningococcal Vaccine Waiver

I have read and reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

_____
Signature of Student or Parent/Legal Guardian Date

SIGN HERE

_____
Health Care Provider or Health Department Signature Date

Medical Exemption -- *Does not apply to tuberculosis (TB) Screening/Testing

As specified in the Code of Virginia §23-7.3, I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap:[ ]; DT/Td:[ ]; OPV/IPV:[ ]; Hib:[ ]; Pneum:[ ]; Measles:[ ]; Rubella:[ ]; Mumps:[ ]; HBV:[ ]; Varicella:[ ]; Meningococcal:[ ] This contraindication is permanent: [ ] or temporary [ ] and expected to preclude immunizations until: Date (Mo., Day, Yr.):_____

_____
Signature of Medical Provider/Health Department Official Date