Longwood Medical Area Child Care Center

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:_____

Date of Birth:_____ **Sex:** ☐ Female ☐ Male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine	Date/Vaccine Type		Vaccine	Date/Vaccine Type	
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
	4			4	
Diphtheria, Tetanus, Pertussis (e.g., DtaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		**Measles, Mumps, Rubella** (MMR)	1	
	2			2	
	3		**Varicella** (Var)	1	
	4			2	
	5		**Hepatitis A** (HepA)	1	
	6			2	
	7			3	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1		**Other:**		
	2				
	3		**Other:**		
	4				

395 Longwood Avenue, Boston, MA 02215 • Telephone: 617-632-2755 Fax: 617-632-2724
Email: kquinn@masco.harvard.edu

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Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles		☐	☐
Mumps		☐	☐
Rubella		☐	☐
Varicella*		☐	☐
Hepatitus B		☐	☐

*** Must also check Chickenpox History Box**

Chickenpox History
☐ Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____

Date: _____

Signature: _____

Facility name: _____

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