

Name _____ Birthdate _____

Address _____ Parent or guardian _____

Telephone _____

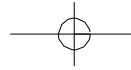
Race/ethnicity: White Black Asian or Pacific Islander American Indian or Alaskan Native

Hispanic origin: Yes No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		



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Address _____ Parent or guardian _____

Telephone _____

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

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.

Signed _____ Date _____
(PHYSICIAN)

RELIGIOUS EXEMPTION

State your reason for requesting this exemption.

PHILOSOPHICAL/STRONG MORAL OR ETHICAL CONVICTION EXEMPTION

State your reason for requesting this exemption.

Signed _____ (Date)
(PARENT OR GUARDIAN)

