

PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE

Name _____ Birthdate _____
 Address _____ Parent or Guardian _____
 Telephone _____

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

VACCINE Circle appropriate item	Enter month, day and year each immunization will be given											
	DOSES											
Diphtheria, tetanus and acellular pertussis (DTaP; DTP; Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Varicella	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Meningococcal (MCV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /
Other	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /

Attach EHR of vaccines already given.

H502.320 3/17

X _____
 Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)