CERTIFICATE OF IMMUNIZATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 16038 (4-2026)

Child's Name: Last, First, Middle Initial	Date of Birth
Parent or Guardian Name	Telephone Number

DTP/DTap/DT: Diphtheria, Tetanus, Pertussis — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Hepatitis A — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Hepatitis B — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Hib: Haemophilus influenzae type B — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

IPV/OPV: Polio — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

MMR: Measles, Mumps, Rubella — Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

PCV: Pneumococcal conjugate Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Rotavirus Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Td/Tdap: Tetanus, Diphtheria, Pertussis Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Varicella: Chickenpox Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Meningococcal: MCV4, Men - ACYW Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Other Immunization

Specify Immunization Type

Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Other Immunization

Specify Immunization Type

Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date
Exempt Type: Select one ◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral				

Other Immunization

Specify Immunization Type

Enter Month, Day, and Year of each date immunization given

Date	Date	Date	Date	Date

Exempt Type: Select one

◯ Medical ◯ History of Disease ◯ Religious ◯ Philosophical or Moral

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician Signature	Date

If additional doses are added after initial signature, please initial dose and sign below.

Update 1

Physician, Nurse, Local, or State Health	Title	Date

Update 2

Physician, Nurse, Local, or State Health	Title	Date

Parent or Guardian Acknowledgment

My child does not meet the minimum immunization requirements for his or her age. I agree to resume immunizations within 30 days of the date I was notified, date noted below, and submit a signed Certificate of Immunization.

Parent or Guardian Signature	Date

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

☐ **Medical Exemption (Med)** - Indicate immunization above, requires physician signature: The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical condition

☐ **History of Disease (HD) Exemption** - Indicate immunization above, requires physician signature: To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician, Nurse, Local, or State Health	Title	Date

Religious (Rel), Philosophical/Moral (PBE) Exemption - Indicate immunization above, requires parent or guardian signature.

Parent or Guardian Signature	Date