B"H

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 OT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, d1pheria and acellular pertussis (Tdap)	1 / /	2 /	3 / /	4 /	5 / /
Polio (OPV o r IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
HepatitisB	1 / /	2 / /	3 / /	4 /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology	Dale	Trter
VariceRa	1 / /	2 / /	Rubella serology	Date	Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

X ______________________

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

H502.320 3/17