H502.320 03/17

PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICALCERTIFICATE

Name_____ Birthdate_____

Address_____ Parent/Guardian Signature _____

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, DT) **1 DOSE ≥ 4TH BIRTHDAY****	1 / /	2 / /	3 / /	**4**** / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV) **1 DOSE ≥ 4TH BIRTHDAY****	1 / /	2 / /	3 / /	**4**** / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology Date		Titer
Varicella	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Varicella disease diagnosed by a physician: Date_____ Mumps disease diagnosed by a physician: Date_____		

ATTACH CURRENT IMMUNIZATION RECORD!!!

X_____ H502.320 3/17

Signature (CIRCLE - PHYSIICIAN, CERTIFIED RN PRACTIONER, PHYSICIANS ASSISTANT, LOCAL HEALTH DEPARTMENT)