Instructions for completing the Certificate of Immunization Status

Contact information:

Complete information for your child including full name, birthdate, current mailing address, parents' or guardians' names and home telephone number. This information will be used to contact you if there are questions about your child's immunization history.

Required vaccines (Front):

Fill in the month/day/year that your child received each dose of vaccine. If you do not have the specific date, month and year only will be accepted. Doses must be listed in the order received. The shaded boxes on the form indicate doses that are not routinely given, however if your child received them, please write the date in the shaded box. Check with your child's school or daycare to find out which vaccines are required for your child's age or grade.

Recommended vaccines (Back):

These doses are not required by law, however most children receive them. Fill in the month/day/year that your child received each dose of vaccine. If you do not have the specific date, list month and year only. Doses should be listed in the order received. The shaded boxes on the form indicate doses that are not routinely given, however if your child received them, please write the date in the shaded box.

Signature:

The parent or guardian signature is a sworn statement that the child's record is accurate. The signature of a physician or local health department is not required but it is acceptable. **Every time you add on to your child's information you need to resign the form.**

REMEMBER TO COMPLETE BOTH SIDES OF FORM

Exemptions:

Oregon allows both religious and medical exemptions. For a religious exemption, indicate which vaccines you are exempting from by checking the boxes. Then sign and date on the indicated line. For a medical exemption, submit a letter from your child's physician to the school or child care.

Oregon Certificate of Immunization Status
Oregon Department of Human Services, Immunization Program

Oregon law requires proof of immunization be provided or a religious or medical exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Department of Human Services, Immunization Program and may be released to the Department or the local Public Health Authority by the school or children's facility upon request of the Department. Vaccine history must include at least the month and year. Please list immunizations in the order they were received.

Complete for all | Up-to-date | Medical | Religious

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*
Mailing Address *Dirección*	City *Ciudad*	State *Estado*	Zip Code *Codigo Postal*
Parents' or Guardians' Names *Nombre de los padres o guardian*		Home Telephone Number *Número de Teléfono*	

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap (not given prior to 10 years of age)					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease _____ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR) *or* Measles vaccine only Mumps vaccine only Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* _____
Date

Update Signature _____
Date

Update Signature _____
Date

Update Signature _____
Date

*Parent, guardian, child at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

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Oregon Department of Human Services, Immunization Program

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Pneumococcal (PCV7) (Only children less than 5 years)					
Meningococcal (MCV4, MPSV4)					
Human Papilloma Virus (HPV) (Only girls age 9 years or older)					
Influenza (Flu)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Exemptions (history of disease or positive titer): **Please submit a *letter* signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Religious exemption:

I have read and understand the information in the brochure that I received. I am aware of the potential risks of my child being unimmunized, including being excluded from attending school during a disease outbreak. My child is being raised as an adherent to a religion the teachings of which are opposed to immunization and I request that my child be exempted from the following required immunizations:

Diphtheria/ Tetanus	☐	Pertussis	☐
Measles	☐	Polio	☐
Mumps	☐	Varicella	☐
Rubella	☐	Hib	☐
Hepatitis B	☐	Hepatitis A	☐

Signature of Parent or Guardian _____ Date

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____ Date

Update Signature _____ Date

Update Signature _____ Date

Update Signature _____ Date