IOWA | Health and Human Services

Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (_____)_____

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			

Vaccine	Vaccine Type	Date Given	Source
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write “Immune to Varicella”.

I certify the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Name (Print): _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____ Date: _____
Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

July 2024