COMMONWEALTH OF KENTUCKY
IMMUNIZATION CERTIFICATE

(Required of each child enrolled in a public or private school, preschool program, day care center, certified family child care home, or other licensed facility which cares for children.)

Name of Child______________________________ Birthdate__________
(Last) (First) (Middle)

Name of Parent or Guardian______________________________

Address______________________________
(Street) (City) (State) (Zip Code)

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___ #5___/___/___

POLIO VACCINES #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___

MMR (Measles, Mumps, Rubella)** #1___/___/___ #2___/___/___ ________ ___/___/___ ________ ___/___/___
Other Other

Hib*** #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___

Hepatitis B**** #1___/___/___ #2___/___/___ #3___/___/___ or #1___/___/___ #2___/___/___ (adult dose)

Varicella ***** #1___/___/___ or child has had chickenpox disease (X) ______.

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease.

This child is current for immunizations until ___/___/___, (two weeks after the next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

Signature of physician, Health Dept., or their designee______________________________Date__________

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

EPID-230 (Rev 8/2002)

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