

# Iowa Department of Public Health Certificate of Immunization

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

Physician, Physician Assistant, Nurse, or Certified Medical Assistant  
 A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Vaccine	Date Given	Doctor / Clinic / Source
<b>Diphtheria, Tetanus, Pertussis</b> DTaP/DTp/DT/Td/Tdap		

<b>Polio</b> IPV/OPV	Date Given	Doctor / Clinic / Source

<b>Measles, Mumps, Rubella</b> MMR	Date Given	Doctor / Clinic / Source

<b>Haemophilus influenzae type b</b> Hib	Date Given	Doctor / Clinic / Source

<b>Hepatitis B</b>	Date Given	Doctor / Clinic / Source

<b>Varicella</b> Chicken Pox If patient has a history of natural disease write "Immune to Varicella"	Date Given	Doctor / Clinic / Source

<b>Pneumococcal PCV/PPV</b>	Date Given	Doctor / Clinic / Source

Vaccine	Date Given	Doctor / Clinic / Source
<b>Meningococcal</b> MCV4/MPSV4		

<b>Hepatitis A</b>	Date Given	Doctor / Clinic / Source

<b>Rotavirus</b>	Date Given	Doctor / Clinic / Source

<b>Human Papilloma Virus</b> HPV	Date Given	Doctor / Clinic / Source

<b>Other</b>	Date Given	Doctor / Clinic / Source

### Licensed Child Care Requirements

**4 through 5 months**      **12 through 18 months**      **19 through 23 months**      **24 months and older**  
 1 dose D/1/P      3 doses Polio      4 doses D/1/P      same requirements as the 19-23 months Except Pneumococcal, 4 doses Pneumococcal if series ≥ 12 months of age, or 1 dose Hib with the final dose in the series ≥ 12 months of age, or 1 dose Measles/Rubella ≥ 12 months of age  
 1 dose Polio      Hib or 1 dose received at ≥ 15 months of age, or 1 dose Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if has not received any previous doses; or received 1 dose ≥ 12 months of age      1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease      Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age

**4 years of age and older:**  
 Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.  
 Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003.  
 Measles/Rubella: the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.  
 Hepatitis B if born on or after July 1, 1994.  
 Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.

**Elementary/Secondary School Requirements**