

Name _____ Birthdate _____

Address _____ Parent or guardian _____

Telephone _____

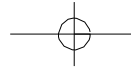
Race/ethnicity: White Black Asian or Pacific Islander American Indian or Alaskan Native

Hispanic origin: Yes No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

PENNSYLVANIA DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date Titer		
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date Titer		
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		



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Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

MEDICAL EXEMPTION

The physical condition of the above-named child is such that immunization would endanger their life or health.

Signed _____
(PHYSICIAN)

_____ Date

RELIGIOUS EXEMPTION

State your reason for requesting this exemption.

PHILOSOPHICAL / STRONG MORAL / ETHICAL CONVICTION EXEMPTION

State your reason for requesting this exemption.

Signed _____

(PARENT OR GUARDIAN)

(Date)

