KIDDIE ACADEMY®
EDUCATIONAL CHILD CARE

IMMUNIZATION CERTIFICATE

CHILD NAME:_____
LAST FIRST MI

SEX: **MALE** □ **FEMALE** □ **AGE:** _____ **BIRTH DATE:**_____
MONTH DAY YEAR

PARENT/ GUARDIAN **NAME:**_____ **PHONE NO.**_____
ADDRESS:_____ **CITY:**_____ **ZIP:**_____
COUNTY: _____

RECORD OF IMMUNIZATION

DOSE NUMBER	DTP MO/DAY/YR	DT (PED) MO/DAY/YR	HEB B MO/DAY/YR	POLIO MO/DAY/YR	MEASLES* MO/DAY/YR	RUBELLA* MO/DAY/YR	MUMPS* M0/DAY/YR	HIB vaccine MO/DAY/YR	VARICELLA MO/DAY/YR
1ST DOSE									
2ND DOSE									
3RD DOSE									
4TH DOSE									
5TH DOSE									

*Blood test verification of immunity and date may be entered in lieu of vaccination date.

PHYSICIAN, HEALTH OFFICIAL) TO THE BEST OF MY KNOWLEDGE, THE VACCINES LISTED ABOVE WERE ADMINISTERED AS INDICATED.

Signed:_____
(Physician or Health Official)

Title:_____

Date:_____

LOST OR DESTROYED RECORD: (Must Be Reviewed and Approved by Local Health Department)
I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable. To the best of my knowledge, the doses of DTP and TOPV listed above were administered on the dates indicated.

Signed:_____ Date: _____
(Parent or Guardian)

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.

This is a permanent condition □ This is a temporary condition □ until:_____
MO/DAY/YR

Check appropriate box; indicate vaccine(s) and reasons below.

_____

_____

Signed:_____ Date:_____
(Physician or Health Official)

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.

Signed_____ Date_____
(Parent or Guardian)