COMPLETE FOR ALL (PINK)	UP-TO-DATE (GOLD)	MEDICAL (PURPLE)	RELIGIOUS (BLUE)	DTP/DT/Td/ DTAP (YELLOW)	#1 DATE DUE	#2 DATE DUE	#3 DATE DUE	#4 DATE DUE	#5 DATE DUE	POLIO (BLACK)	#1 DATE DUE	#2 DATE DUE	#3 DATE DUE	#4 DATE DUE	VARICELLA (ORANGE)	#1 DATE DUE	#2 DATE DUE	MMR (RED)	#1 DATE DUE	#2 DATE DUE	HEPATITIS B (SILVER)	#1 DATE DUE	#2 DATE DUE	#3 DATE DUE	HIB Haemophilus b (GREEN)	#1 DATE DUE	#2 DATE DUE	#3 DATE DUE	#4 DATE DUE

If you need this form in an alternate format, please call the Immunization Program at 503-731-4020

CERTIFICATE OF IMMUNIZATION STATUS - Oregon Dept. of Human Services / Health Division

To attend an Oregon school, childcare facility, home day care or preschool, proof of immunization must be provided or a properly documented religious or medical exemption signed. The vaccine history must include the month and year in which each dose was received. Vaccine dates should be listed in the order received.

NAME OF SCHOOL / FACILITY

STUDENT I.D. #

GRADE

LAST NAME | FIRST | MIDDLE | SEX | BIRTHDATE (MO / DAY / YR) | COUNTRY OF BIRTH

MAILING ADDRESS | CITY | STATE | ZIP

PARENT(S) NAME | TELEPHONE (WORK) | (HOME)

SECTION A VACCINE HISTORY

DIPHTHERIA/TETANUS CONTAINING VACCINES
DTaP/DT/DTP/Td

DOSE	MO	DAY	YR	INITIAL / DATE FOR UPDATES
1				
2				
3				
4				
5				
6				

POLIO: ORAL (OPV) or INJECTABLE (IPV)

	MO	DAY	YR	
1				
2				
3				
4				
5				

VARICELLA VACCINE (CHICKENPOX)

	MO	DAY	YR	
1				
2				

OR

HISTORY OF DISEASE YES ____ NO ____

SECTION A VACCINE HISTORY

MMR (Measles, Mumps, Rubella, combined) DOSE	MO	DAY	YR	INITIAL / DATE FOR UPDATES
1				
2				

OR

MEASLES (Single Dose)				
RUBELLA (Single Dose)				
MUMPS (Single Dose)				

HEPATITIS B (HEP B)

	MO	DAY	YR	
1				
2				
3				

HAEMOPHILUS INFLUENZAE type b (Hib)
Required if under 5 years old

	MO	DAY	YR	
1				
2				
3				
4				

OTHER

	MO	DAY	YR	

SECTION B
MEDICAL EXEMPTION

(To be completed by a physician or county health department representative)

I CERTIFY THAT THIS CHILD SHOULD BE EXEMPTED FROM THE REQUIREMENTS FOR THE FOLLOWING VACCINES:

☐ DIPHTHERIA ☐ MEASLES ☐ POLIO
☐ TETANUS ☐ RUBELLA ☐ Hib
☐ VARICELLA ☐ MUMPS ☐ HEPATITIS B

BASED ON:

☐ HISTORY OF DISEASE (MO / YR) _____

OR

☐ The following reason which constitutes a medical contraindication in accordance with the Advisory Committee on Immunization Practices of the U.S. Public Health Service for the vaccine(s) indicated.

REASON

PHYSICIAN OR COUNTY HEALTH DEPT. (PLEASE PRINT) | PHONE

SIGNATURE PHYSICIAN OR COUNTY HEALTH DEPT. (M.D. N.D. D.O. R.N.) | DATE

MEDICAL EXEMPTION REVIEW
(TO BE COMPLETED BY HEALTH DEPARTMENT REPRESENTATIVE ONLY)

☐ PERMANENT _____ DATE _____ VACCINE(S)

☐ TEMPORARY _____ REVIEW DATE

NEXT REVIEW DATE: _____

I CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT. PLEASE CHECK APPROPRIATE BOX BELOW.

SIGNATURE _____
☐ PARENT / GUARDIAN ☐ HEALTHCARE PRACTITIONER ☐ HEALTH DEPT. REP. DATE

UPDATE SIGNATURE #1 _____
☐ PARENT / GUARDIAN ☐ HEALTHCARE PRACTITIONER ☐ HEALTH DEPT. REP. DATE

UPDATE SIGNATURE #2 _____
☐ PARENT / GUARDIAN ☐ HEALTHCARE PRACTITIONER ☐ HEALTH DEPT. REP. DATE

✻ Parent means: Parent, guardian, any adult responsible for the child, a person who is emancipated or student at least 18 years of age.

FOR ADDITIONAL INFORMATION REGARDING VACCINES, THE RISKS OF NON-IMMUNIZATION AND THE OREGON LAW, PLEASE SEE THE BACK OF THIS FORM.

53-05A 7/00

COUNTY HEALTH DEPARTMENT/DATA PROCESSING COPY

SECTION C
RELIGIOUS EXEMPTION

I have read and understand the information on the reverse side of this form and I am aware of the potential risks of being unimmunized. My child is being raised as an adherent to a religion the teachings of which are opposed to immunization and I request that my child therefore be exempted from immunization requirements.

SIGNATURE OF PARENT ✻ | DATE