

SAUGUS HIGH SCHOOL

Athletic Department

CERTIFICATE OF IMMUNIZATION

Name _____ DOB ____ / ____ / _____ Male Female (circle one)

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

| Vaccine | Date/ | Vaccine Type | Serologic Proof of Immunity | | Check One | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------|---|------|-----------|----------|---------------------------|--|--|--|--|--|--|--|---------|--|--|--|------------|--|--|--|-------------|--|--|--|---|--|--|
| Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV) | 1 | | Test (if done) | Date | positive | negative | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Measles</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> <tr> <td>Mumps</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rubella</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Varicella*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hepatitis B</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4" style="text-align: center;">*must also check Chickenpox History Box</td> </tr> </table> | | | | Measles | | | | Mumps | | | | Rubella | | | | Varicella* | | | | Hepatitis B | | | | *must also check Chickenpox History Box | | |
| Measles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mumps | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rubella | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Varicella* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *must also check Chickenpox History Box | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="text-align: center;">Chickenpox History</td> </tr> <tr> <td colspan="4" style="padding: 10px;"> <input type="checkbox"/> check the box if this person has a physician-certified reliable history of chicken pox Reliable history may be based on: - physician interpretation of parent/guardian description of chicken pox - physical diagnosis of chicken pox, or - serologic proof of immunity </td> </tr> </table> | | | | Chickenpox History | | | | <input type="checkbox"/> check the box if this person has a physician-certified reliable history of chicken pox Reliable history may be based on: - physician interpretation of parent/guardian description of chicken pox - physical diagnosis of chicken pox, or - serologic proof of immunity | | | | | | | | | | | | | | | | | | |
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| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Polio (e.g., IPV, DTaP-HepB-IPV) | 1 | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="text-align: center;">Chickenpox History</td> </tr> <tr> <td colspan="4" style="padding: 10px;"> <input type="checkbox"/> check the box if this person has a physician-certified reliable history of chicken pox Reliable history may be based on: - physician interpretation of parent/guardian description of chicken pox - physical diagnosis of chicken pox, or - serologic proof of immunity </td> </tr> </table> | | | | Chickenpox History | | | | <input type="checkbox"/> check the box if this person has a physician-certified reliable history of chicken pox Reliable history may be based on: - physician interpretation of parent/guardian description of chicken pox - physical diagnosis of chicken pox, or - serologic proof of immunity | | | | | | | | | | | | | | | | | | |
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| 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pneumococcal Conjugate (PCV7) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Haemophilus influenzae</i> type b (e.g., Hib, HepB-Hib, DTaP-Hib) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Measles, Mumps, Rubella (MMR) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Varicella (Var) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hepatitis A (HepA) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pneumococcal Polysaccharide (PPV23) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Influenza Inactivated (intramuscular) or Live (intranasal) | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____ Date ____ / ____ / _____

Signature _____

Facility name _____

| Vaccine | | Date/ Vaccine Type |
|--|---|--------------------|
| | 1 | |
| | 2 | |
| | 3 | |
| Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| | 5 | |
| | 6 | |
| | 7 | |
| Polio (e.g., IPV, DTaP-HepB-IPV) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| Pneumococcal Conjugate (PCV7) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |

| Vaccine | | Date/ Vaccine Type |
|--|---|--------------------|
| Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV) | 1 | |
| | 2 | |
| | 3 | |
| Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| Varicella (Var) | 1 | |
| | 2 | |
| Hepatitis A (HepA) | 1 | |
| | 2 | |
| Pneumococcal Polysaccharide (PPV23) | 1 | |
| | 2 | |
| Influenza Inactivated (intramuscular) or Live (intranasal) | 1 | |
| | 2 | |
| | 3 | |
| Other: | | |
| <i>Haemophilus influenzae</i> type b (e.g., Hib, HepB-Hib, DTaP-Hib) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| Measles, Mumps, Rubella (MMR) | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |
| Varicella (Var) | 1 | |
| | 2 | |
| Hepatitis A (HepA) | 1 | |
| | 2 | |
| Pneumococcal Polysaccharide (PPV23) | 1 | |
| | 2 | |
| Influenza Inactivated (intramuscular) or Live (intranasal) | 1 | |
| | 2 | |
| | 3 | |
| Other: | | |
| | | |
| | | |