COLORADO CERTIFICATE OF IMMUNIZATION



www.coloradoimmunizations.com

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

					Date of birtl	າ:	
Parent/guardian:							
Required vaccines	Immuni:	Immunization date(s) MM/DD/YY					Titer date* MM/DD/YY
Hep B Hepatitis B							
OTaP Diphtheria, Tetanus, Pertussis (pediatric)							
dap Tetanus, Diphtheria, Pertussis							
d Tetanus, Diphtheria							
l ib Haemophilus influenzae type b							
PV/OPV Polio							
CV Pneumococcal Conjugate							
MR Measles, Mumps, Rubella							
Neasles							
lumps							
ubella							
aricella Chickenpox							
aricella - date of disease	- date of disease Varicella - positive screen date				*A positive laboratory titer report must be provide to the school to document immunity.		
Recommended vacci	nes	Immunization	date(s) MM/DD/YY		vaccine.	ptable proof of immuni	•
ota Rotavirus							
ICV4/MPSV4 Meningococcal							
<u> </u>							
en B Meningococcal							
ACV4/MPSV4 Meningococcal Men B Meningococcal Mep A Hepatitis A							
en B Meningococcal ep A Hepatitis A lu Influenza							
len B Meningococcal lep A Hepatitis A lu Influenza							
len B Meningococcal lep A Hepatitis A lu Influenza	r stamp	:			Date:		
en B Meningococcal ep A Hepatitis A lu Influenza ther ealth care provider signature o			(circle one):	Yes No	Date:		
en B Meningococcal ep A Hepatitis A lu Influenza ther ealth care provider signature o tudent is current on required in	nmuniza	ations for age			Date:		
len B Meningococcal	nmuniza	ations for age			Date:		
Nen B Meningococcal Iep A Hepatitis A Iu Influenza Other Iealth care provider signature of tudent is current on required in OR	mmuniza d/review	ntions for age			Date:		
en B Meningococcal ep A Hepatitis A lu Influenza ther lealth care provider signature o tudent is current on required in OR mmunization record transcribed	mmunizad/review e or star	ved by school mp:	health authority	records with st	Date:	health agencies and	the