



## Oregon Certificate of Immunization Status Oregon Department of Human Services, Immunization Program

Oregon law requires proof of immunization be provided or a religious or medical exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Department of Human Services, Immunization Program and may be released to the Department or the local Public Health Authority by the school or children's facility upon request of the Department. Vaccine history must include at least the month and year. Please list immunizations in the order they were received.

Child's Last Name Apellido	First Primer Nombre	Middle Initial Segundo Nombre	Birthdate Fecha de Nacimiento
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Mailing Address Dirección	City Ciudad	State Estado	Zip Code Codigo Postal
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Parents' Names Nombre de los padres	Home Telephone Number Número de Teléfono
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	Required Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Required Vaccines	Diphtheria/Tetanus (DTaP, DT, Td, TdaP) <input type="checkbox"/> Check here if child did <b>not</b> receive pertussis vaccine	(mm/dd/yy) / /	(mm/dd/yy) / /	(mm/dd/yy) / /	(mm/dd/yy) / /	(mm/dd/yy) / /
	Polio (IPV or OPV)	/ /	/ /	/ /	/ /	/ /
	Varicella (Chickenpox) [VZV or VAR] <input type="checkbox"/> Check here if child has had chickenpox disease / / (mm/dd/yy)	/ /	/ /	/ /	/ /	/ /
	Measles/Mumps/Rubella (MMR) <i>or</i> Measles vaccine only	/ /	/ /	/ /	/ /	/ /
	Mumps vaccine only	/ /	/ /	/ /	/ /	/ /
	Rubella vaccine only	/ /	/ /	/ /	/ /	/ /
	Hepatitis B (Hep B)	/ /	/ /	/ /	/ /	/ /
	Haemophilus Influenzae Type B (Hib) Required only under age 5 years	/ /	/ /	/ /	/ /	/ /

**I certify that the above information is an accurate record of this child's immunization history.**

Signature\* \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>For school/facility use only</b>
School/facility Name
Student ID Number
Grade

\*Parent, guardian, child at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

**Continued On Reverse Side**



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**Oregon Department of Human Services, Immunization Program**

Child's Last Name Apellido	First Nombre	Middle Initial Segundo Nombre	Birthdate Fecha de Nacimiento
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	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Recommended Vaccines	Tetanus/Diphtheria Booster (TdaP or Td)	/ /	/ /	/ /	/ /	/ /
	Hepatitis A (Hep A)	/ /	/ /	/ /	/ /	/ /
	Pneumococcal (PCV7) (Children under 5 years)	/ /	/ /	/ /	/ /	/ /
	Meningococcal (MCV4) (Children 11-18 years)	/ /	/ /	/ /	/ /	/ /
	Other Vaccine Please specify:	/ /	/ /	/ /	/ /	/ /
	Other Vaccine Please specify:	/ /	/ /	/ /	/ /	/ /
	Other Vaccine Please specify:	/ /	/ /	/ /	/ /	/ /

**For medical exemptions:**

Please submit a **letter** signed by a licensed physician stating:

- Child's name
- Birth Date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature

Physician's contact information, including phone number

**For Immunity Exemptions:**

Please submit a **letter** signed by a licensed physician stating:

- Child's name and Birth Date
- Diagnosis or lab report
- Physician's signature

**Religious exemption:**

I have read and understand the information in the brochure that I received. I am aware of the potential risks of my child being unimmunized, including being excluded from attending school during a disease occurrence. 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 be exempted from the following required immunizations:

- |            |                          |             |                          |
|------------|--------------------------|-------------|--------------------------|
| Diphtheria | <input type="checkbox"/> | Measles     | <input type="checkbox"/> |
| Tetanus    | <input type="checkbox"/> | Mumps       | <input type="checkbox"/> |
| Polio      | <input type="checkbox"/> | Rubella     | <input type="checkbox"/> |
| Varicella  | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> |
| Hib        | <input type="checkbox"/> |             |                          |

Signature of Parent or Guardian

Date

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_