



Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:

Reviewed by: _____ Date: _____
Signed Cert. of Exemption on file? Yes No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:	I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.	
Symbols below: <input checked="" type="checkbox"/> Required for School and Child Care/Preschool <input type="checkbox"/> Required for Child Care/Preschool Only <input type="checkbox"/> Recommended, but not required						
I certify that the information provided on this form is correct and verifiable.					Parent/Guardian Signature Required _____	Date _____

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
■ Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap)				
	1			
■ Tetanus, Diphtheria (Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
■ Influenza (flu, most recent)				

Vaccine	Dose	Date		
		Month	Day	Year
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			
	5			
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox)				
	1			
	2			
■ Hepatitis A (Hep A)				
	1			
	2			
■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand				
	1			
	2			
	3			
■ Meningococcal (MCV, MPSV)				
	1			
	2			

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, OR 3 below (see # 5 on back)

1) Chickenpox disease verified by printout from the Immunization Information System (IIS)
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by healthcare provider (HCP)
If you choose this box, mark 2A OR 2B below.
2A) Signed note from HCP attached OR
2B) HCP sign here and print name below:

Licensed healthcare provider signature Date
(MD, DO, ND, PA, ARNP)

Printed Name: _____

3) Chickenpox disease verified by school staff from the Immunization Information System

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

Licensed healthcare provider signature Date
(MD, DO, ND, PA, ARNP)

Printed Name: _____

