SCHOOL ENTRANCE
IMMUNIZATION CERTIFICATION

CERTIFICATION OF IMMUNIZATION: To Be Completed by Examining Physician

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines **shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form**. Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official.

Student's Name: _____ Date of Birth: _____/ _____/ _____
(First, Middle, and Last)

IMMUNIZATION	RECORD COMPLETE DATES OF VACCINE DOSES GIVEN (month, day, year)				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Tdap Booster (6th grade entry)	1	2	3	4	5
*Updated Tetanus	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenza Type b (Hib conjugate)	1	2	3	4	
*Pneumococcal (PCV conjugate)	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)					
*Rubella					
*Mumps					
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1	2			
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, prescribed by the State Board of Health.

_____ _____/ _____/ _____
Signature of Physician or Health Department Official Date

MEDICAL EXEMPTION: ☐ DTP ☐ Td ☐ OPV ☐ Measles ☐ Rubella ☐ Mumps
As specified in Virginia Code, I certify that administration of the vaccine(s) designated above would be detrimental to the student's health. The vaccine(s) is (are) specifically contraindicated because:

_____

The contraindication is: ☐ permanent, or ☐ temporary and expected to preclude immunization until _____/ _____/ _____.

_____ _____/ _____/ _____
Signature of Physician or Health Department Official Date

CONDITIONAL ENROLLMENT: I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days.

Next immunization due on _____/ _____/ _____. _____ _____/ _____/ _____
Signature of Physician or Health Department Official Date