_____ County School Health Services

CERTIFICATE OF IMMUNIZATION

For Middle School and High School Students

Updated Immunization Record

Student's Name: _____ **DOB:** _____
Last First Middle Month/Day/Year

Parent Name: _____ **School:** _____

Hepatitis B:	_____ Date	_____ Date	_____ Date	**Meningococcal:**	_____ Date	_____ Date
HPV:	_____ Date	_____ Date	_____ Date	**Tdap:**	_____ Date	
Varicella:	_____ Date	_____ Date				

Recorded By: Licensed Provider/Clinic Name (Please Print)	Authorized Signature	Phone Number	Date
_____	_____	_____	_____

Permanent Medical Exemption

I certify that the physical condition of this child is such that immunizations are medically contraindicated. List vaccine(s) and state valid clinical reasoning or evidence for exemption:

_____

_____

Recorded By: Licensed Provider/Clinic Name (Please Print)	Authorized Signature	Phone Number	Date
_____	_____	_____	_____

Received and approved the _____ County Health Officer: _____ Signature: _____ Date: _____

Please refer any questions/concerns to: Name, Title, Phone Number