



Oregon Certificate of Immunization Status Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an 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 Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>	Complete for all Up-to- date
Mailing Address <i>Dirección</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Código Postal</i>	
Parents' or Guardians' Names <i>Nombre de los padres o guardian</i>		Home Telephone Number <i>Número de Teléfono</i>		Medical Non medical

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap					
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)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 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 _____

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

*Parent, guardian, student 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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Save

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
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Recommended Vaccines	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	Pneumococcal (PCV) (Only in children less than 5 years)					
	Meningococcal (MCV4, MPSV4)					
	Human Papilloma Virus (HPV) (9 years or older)					
	Influenza (Flu)					
	Other Vaccine Please specify:					
	Other Vaccine Please specify:					

<p>For medical exemptions: Please submit a letter signed by a licensed physician stating:</p> <ul style="list-style-type: none"> ▪ Child's name ▪ Birth date ▪ Medical condition that contraindicates vaccine ▪ List of vaccines contraindicated ▪ Approximate time until condition resolves, if applicable ▪ Physician's signature and date ▪ Physician's contact information, including phone number <p>For Immunity Documentation (history of disease or positive titer): Please submit a letter signed by a licensed physician stating:</p> <ul style="list-style-type: none"> ▪ Child's name and birth date ▪ Diagnosis or lab report ▪ Physician's signature and date 	<p>Nonmedical Exemption: I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):</p> <p><input type="checkbox"/> A health care practitioner <input type="checkbox"/> The vaccine educational module approved by the Oregon Health Authority</p> <p>I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Diphtheria/ Tetanus/Pertussis</td> <td><input type="checkbox"/> Hepatitis B</td> </tr> <tr> <td><input type="checkbox"/> Polio</td> <td><input type="checkbox"/> Hepatitis A</td> </tr> <tr> <td><input type="checkbox"/> Varicella</td> <td><input type="checkbox"/> Hib</td> </tr> <tr> <td><input type="checkbox"/> Measles/Mumps/Rubella</td> <td></td> </tr> </table> <hr/> <p>Signature of Parent or Guardian _____ Date _____</p> <p>Optional: ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:</p> <p><input type="checkbox"/> Religious belief <input type="checkbox"/> Philosophical belief <input type="checkbox"/> Other</p>	<input type="checkbox"/> Diphtheria/ Tetanus/Pertussis	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Polio	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Varicella	<input type="checkbox"/> Hib	<input type="checkbox"/> Measles/Mumps/Rubella	
<input type="checkbox"/> Diphtheria/ Tetanus/Pertussis	<input type="checkbox"/> Hepatitis B								
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<input type="checkbox"/> Varicella	<input type="checkbox"/> Hib								
<input type="checkbox"/> Measles/Mumps/Rubella									

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 _____