COLORADO CERTIFICATE OF IMMUNIZATION





This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name:	Student Name:				Date of birth:		
Parent/guardian:							
Required vaccines	Immunization date(s) MM/DD/YY				Titer date* MM/DD/YY		
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib Haemophilus influenzae type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							
/aricella - date of disease		Varicella - positive screen date		*A positive laboratory titer report must be provided to the school to document immunity.			
Recommended vacci	ines	Immunization date(s) MM/DD/YY			under "Titer date" indicates that able proof of immunity for this		
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							
Health care provider signature or stamp:				Date:			
Student is current on required ir	nmuniza	ations for age (circle one):	Yes No				
OR							
Immunization record transcribed	l/review	ved by school health authority	/ :				
School health authority signature or stamp:				Date:			
(Optional) I authorize my/my student's Colorado Immunization Information Systo				e/local public h	ealth agencies and the		
Parent/Guardian/Student (emancipated	or over 1	8 vrs old) signature:		Date:			