



**CERTIFICATE OF IMMUNIZATION**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 SFN 16038 (Revised 03-2007)

Division of Disease Control  
 600 East Boulevard Ave. Dept 301  
 Bismarck, ND 58505-0200  
 800.427.2180 or 701.328.3386

**North Dakota law requires this form be completed\* and provided to the childcare facility or school.**

| Child's Name (Last, First, Middle Initial): |                                     | Date of Birth:                                   |  |  |  |
|---|-------------------------------------|--|--|--|--|
| Parent's Name:                              |                                     | Telephone Number:                                |  |  |  |
| Vaccine Type                                |                                     | Enter Month/Day/Year for Each Immunization Given |  |  |  |
| DTP/DTaP/DT                                 | Diphtheria-Tetanus-Pertussis        |  |  |  |  |
| OPV/IPV                                     | Polio                               |  |  |  |  |
| Hib   | Haemophilus influenzae type B       |  |  |  |  |
| MMR   | Measles-Mumps-Rubella               |  |  |  |  |
| Hepatitis B                                 | Hepatitis B                         |  |  |  |  |
| Hepatitis A                                 | Hepatitis A                         |  |  |  |  |
| Varicella                                   | Chickenpox                          | History of Disease - Yes ____<br>Date: _____     |  |  |  |
| PCV 7                                       | Pneumococcal Conjugate              |  |  |  |  |
| Rotavirus                                   | Rotavirus                           |  |  |  |  |
| Td/Tdap                                     | Tetanus-Diphtheria and/or Pertussis |  |  |  |  |
| MCV4/MPSV4                                  | Meningococcal                       |  |  |  |  |
| HPV   | Human Papillomavirus                |  |  |  |  |
| Other                                       |                                     |  |  |  |  |

**To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.**

|                                      |       |      |
|--------------------------------------|-------|------|
| Physician, Nurse, Local/State Health | Title | Date |
|--------------------------------------|-------|------|

**If additional doses are added after initial signature, please initial dose and sign below.**

|                                       |        |       |
|---------------------------------------|--------|-------|
| Update signature #1:                  |        |       |
| Physician, Nurse, Local/State Health: | Title: | Date: |
| Update signature #2:                  |        |       |
| Physician, Nurse, Local/State Health: | Title: | Date: |

**My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.**

|                            |       |
|----------------------------|-------|
| Parent/Guardian Signature: | Date: |
|----------------------------|-------|

**Statement of Exemption to Immunization Law**  
 In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

**Medical Exemption:** The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

|                      |       |
|----------------------|-------|
| Physician Signature: | Date: |
|----------------------|-------|

**Religious/Philosophical/Moral Belief Exemption:** Parent or guardian of the above-named person adheres to a belief opposed to immunizations. (Please check one)     Religious                       Philosophical                       Moral

|                           |      |
|---------------------------|------|
| Parent/Guardian Signature | Date |
|---------------------------|------|

\* See back of form for assistance.  
**Original (white)** – child care facility or school copy. **Copy (yellow)** – to be retained by parent/guardian.

## Provider Instructions for Use of Certificate of Immunization

### MINIMUM REQUIREMENTS<sup>1</sup>

Children/students must be immunized age-appropriately according to the Advisory Committee of Immunization Practices (ACIP) and the Centers for Disease Control and Prevention. (See below.)

#### I. Childcare Facility Attendance:

| Vaccine Type  | Minimum Number of Doses Required Per Age |            |             |                |                        |
|---|--|------------|-------------|----------------|------------------------|
|   | 2-3 Months                               | 4-5 Months | 6-11 Months | 12-18 Months   | 4-6 Years              |
| <b>DTaP/DTP/DT</b><br>(Diphtheria-Tetanus-Pertussis)              | 1  | 2          | 3           | 4              | 4 or more <sup>*</sup> |
| <b>Hib<sup>§</sup></b><br>( <i>Haemophilus influenzae</i> type b) | 1  | 2          | 2 or 3      | 3 or 4         | 3 or 4                 |
| <b>IPV/OPV<sup>†</sup></b><br>(Polio)                             | 1  | 2          | 2           | 3              | 4                      |
| <b>MMR</b><br>(Measles-Mumps-Rubella)<br>Minimum age: 12 months   | 0  | 0          | 0           | 1              | 2                      |
| <b>Varicella</b><br>(Chickenpox)                                  | 0  | 0          | 0           | 1 <sup>#</sup> | 1 <sup>#</sup>         |

\* One dose must have been given on or after the fourth birthday. For students  $\geq 7$  years who have not had the required number of pertussis doses, no new or additional doses are required.

§ If the first dose is given at 15 months or older, only one dose of Hib is required. The number of doses required depends on the type of vaccine given for the first two doses. Children age 5 and older are exempt from the Hib requirement.

† In all IPV or all OPV schedule: If the third dose was given on or after the fourth birthday, the fourth dose is not required.

**Combination of IPV/OPV schedule (2 IPV, followed by 2 OPV):** All four doses are needed regardless of age.

# Effective January 2004, one dose of varicella vaccine is required for children who are 12 months of age or older and attending daycare or an early childhood care facility.

#### II. School Attendance (K-12 and College):

| Vaccine Type  | Minimum Number of Doses Required Per Grade |                        |         |
|---|--|------------------------|---------|
|   | K-6  | Grades 7-12            | College |
| <b>DTaP/DTP/DT/Td</b><br>(Diphtheria-Tetanus-Pertussis) | 4 or more <sup>*</sup>                     | 4 or more <sup>*</sup> |         |
| <b>IPV/OPV</b><br>(Polio)                               | 4 <sup>†</sup>                             | 4 <sup>†</sup>         |         |
| <b>MMR</b><br>(Measles-Mumps-Rubella)                   | 2  | 2 <sup>¶</sup>         | 2       |
| <b>Varicella</b><br>(Chickenpox)                        | 1 <sup>#</sup>                             | 1 <sup>#</sup>         |         |
| <b>Hepatitis B</b>                                      | 3 <sup>£</sup>                             | 3 <sup>£</sup>         |         |

\* One dose must have been given on or after the fourth birthday. Three doses Td required for children age 7 or older not previously vaccinated.

† In all IPV or all OPV schedule: If the third dose was given on or after the fourth birthday, the fourth dose is not required. If a child has received a total of four doses of any combination of OPV and IPV at least four weeks apart, he (she) is considered adequately immunized against polio.

¶ Two doses of MMR given on or after the first birthday are required for children who entered kindergarten or first grade in the 1992/1993 school year and thereafter. Each subsequent year, the next highest grade will be included.

£ Effective with the 2000/2001 school year and thereafter, three doses of hepatitis B vaccine are required for entrance into kindergarten (or first grade if the student's school does not have a kindergarten). Each subsequent year, the next highest grade will be included.

# Effective with the 2004/2005 school year and thereafter, children are required to be age-appropriately immunized with varicella vaccine. Each subsequent year, the next highest grade will be included. Children with history of disease are exempt from getting the vaccine. Documentation of disease is required.

<sup>1</sup> Physician or clinic may recommend additional doses.