# Oregon Certificate of Immunization Status
# Oregon Department of Human Services, Immunization Program

Oregon law requires proof of immunization be provided or a religious or medical 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 Department of Human Services, Immunization Program and may be released to the Department or the local Public Health Authority by the school or children's facility upon request of the Department. Vaccine history must include at least the month and year. Please list immunizations in the order they were received.

| Complete for all | Up-to-date | Medical | Religious |
|---|---|---|---|

| Child's Last Name *Apellido* | First *Primer Nombre* | Middle Initial *Segundo Nombre* | Birthdate *Fecha de Nacimiento* |
|---|---|---|---|
| Mailing Address *Dirección* | City *Ciudad* | State *Estado* | Zip Code *Codigo Postal* |
| Parents' or Guardians' Names *Nombre de los padres o guardian* | | Home Telephone Number *Número de Teléfono* | |

| 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 (not given prior to 10 years of age) | | | | | |
| Polio (IPV or OPV) | | | | | |
| Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease ____________ (mm/dd/yy) | | | | | |
| Measles/Mumps/Rubella (MMR) | | | | | |
| *or* 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

*Parent, guardian, child at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

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

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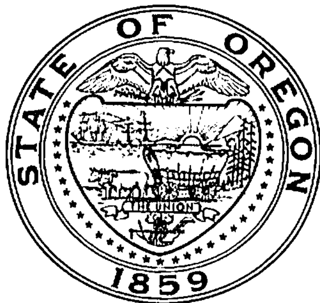


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| Child's Last Name<br>*Apellido* | First<br>*Primer Nombre* | Middle Initial<br>*Segundo Nombre* | Birthdate<br>*Fecha de Nacimiento* |
|---|---|---|---|

**Recommended Vaccines**

| Recommended Vaccines | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|---|---|---|---|---|---|
| Pneumococcal (PCV7)<br>(Only children less than 5 years) | | | | | |
| Meningococcal (MCV4, MPSV4) | | | | | |
| Human Papilloma Virus (HPV)<br>(Only girls age 9 years or older) | | | | | |
| Influenza (Flu) | | | | | |
| Other Vaccine<br>Please specify: | | | | | |
| Other Vaccine<br>Please specify: | | | | | |

## For medical exemptions:

**Please submit a *letter* signed by a licensed physician stating:**

- 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

**For Immunity Exemptions** (history of disease or positive titer):
**Please submit a *letter* signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

## Religious exemption:

I have read and understand the information in the brochure that I received. I am aware of the potential risks of my child being unimmunized, including being excluded from attending school during a disease outbreak. My child is being raised as an adherent to a religion the teachings of which are opposed to immunization and I request that my child be exempted from the following required immunizations:

- Diphtheria/ Tetanus ☐
- Measles ☐
- Mumps ☐
- Rubella ☐
- Hepatitis B ☐
- Pertussis ☐
- Polio ☐
- Varicella ☐
- Hib ☐
- Hepatitis A ☐

Signature of Parent or Guardian ______________________ Date

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