DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS

CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependent Schools (DoDDS) must meet specific immunization requirements. These requirements displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the LOCAL MEDICAL AUTHORITY, MUST be provided to school officials at time of initial registration for placement in the official school records of the student.**

_____	_____	_____
(Please Print) Name of Child	Date of Birth	Parent or Guardian

Instructions for Local Medical Authority: In the spaces provided, write the dates (Mo/day/yr) of each immunization received. In the appropriate space write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: 3 doses: The 2nd dose should be given at least one month after the 1st dose. The 3rd dose should be given at least two months after the second and at least 4 months after the first.

_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine: (Circle vaccine given.) 3 doses given singly or in combination, **at least one of which was administered after the 4th birthday and the last one was given within 10 years** (Td recommended at age 11-12 if more than 5 years have elapsed since the last DTaP/DPT/Td. Subsequent routine Td boosters are required every 10 yrs). ***Pertussis vaccine is not required for individuals older than six (6) years of age.**

DTaP, DTP, Td	DTaP, DTP, Td	DTaP, DTP, Td	DTaP, DTP, Td	DTaP, DTP, Td	DTaP, DTP, Td	DTaP, DTP, Td
_____	_____	_____	_____	_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

HIB (Haemophilus influenza type b): 2 to 4 doses in infancy; 3 and 4 year olds with NO record of Hib in infancy only require ONE Dose.
***Hib immunization is not required for individuals five (5) years of age or older.**

_____	_____	_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Polio Vaccine (Circle vaccine given.) 3 doses of Polio Vaccine (oral or injected), **last one of which was administered after the 4th birthday.**

IPV OPV	IPV OPV	IPV OPV	IPV OPV	IPV OPV
_____	_____	_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

MMR (Measles, Mumps and Rubella): 2 doses of live attenuated vaccine given singly or in combination at least one of which was administered 28 days or more after the 1st dose, but **2nd dose recommended after the 4th birthday.**

_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Varicella Vaccine: 1 dose of Varicella Vaccine through the age of 12 years, 2 doses for those 13 or older (at least one month apart), **or reliable history of the disease.**

DATE CHILD HAD DISEASE PER PARENT REPORT:

_____	_____	_____
Mo/Day/Year	Mo/Day/Year	Mo/Year

PPD: Date: _____Results: Negative ☐ Positive ☐ ___mm. Preventive Medicine Referral Date: _____ INH Date: _____-_____ **BCG**: Date: _____

Other: Specify Vaccine (not to include TB Skin Test)
Vaccine _____ Date _____ Vaccine _____ Date _____

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____ when _____ immunization(s) is/are due.

_____
Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious ___ or medical** ___ reasons must be supported by official documents from church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): _____,
Reason: _____Waver duration: _____.

_____
Signature and Stamp of Medical Authority/Date