CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES
SFN 16038 (Revised 09-2022)

Public Health Division, Immunization Unit
600 E Boulevard Ave, Dept 325
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Type*	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B						
Rotavirus	Rotavirus						
Hib	*Haemophilus influenzae* type B						
PCV	Pneumococcal conjugate						
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis						
IPV/OPV	Polio						
MMR	Measles-Mumps-Rubella						
Varicella	Chickenpox						
Hepatitis A	Hepatitis A						
Td/Tdap	Tetanus-Diphtheria (and Pertussis)						
MCV4	Meningococcal ACYW-135						
HPV	Human Papillomavirus						
Men B	Meningococcal B						
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) 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 (Med) Exemption:*** *(Indicate vaccine above, requires physician signature)* 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.

☐ ***History of Disease (HD) Exemption:*** *(Indicate vaccine above, requires physician signature)* To the best of my knowledge, the above named person has had prior infection with chickenpox disease as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:

Religious (Rel), Philosophical/Moral (PBE) Exemption: *(Indicate vaccine above, requires parental signature)*

Parent/Guardian Signature:	Date:

* **Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE**