CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 05-2012)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 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		Exemption Check type below[€]	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	☐					
OPV/IPV	Polio	☐					
MMR	Measles-Mumps-Rubella	☐					
Varicella	Chickenpox	☐			**History of Disease Date:**		
Hepatitis A	Hepatitis A	☐					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	☐					
MCV4	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:

[€]***Exemption:*** *(Indicate vaccine above)*

(Please check one) ☐ Religious ☐ Philosophical ☐ Moral ☐ History of Disease

Parent/Guardian Signature	Date