PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE

PLAN

Name _____ Birthdate _____

Address _____ Parent or Guardian _____

_____ Telephone _____

Please circle present grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

VACCINE Circle appropriate item	Enter month, day and year each immunization **will be given** DOSES				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology Date		Titer
Varicella	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

X _____ H502.320 3/17

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)

PLAN