

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO

Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____

Date of birth: _____

Parent/guardian: _____

Required vaccines

Immunization date(s) MM/DD/YY

Titer date*
MM/DD/YY

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| Hep B Hepatitis B | | | | | | | |
| DTaP Diphtheria, Tetanus, Pertussis (pediatric) | | | | | | | |
| Tdap Tetanus, Diphtheria, Pertussis | | | | | | | |
| Td Tetanus, Diphtheria | | | | | | | |
| Hib <i>Haemophilus influenzae</i> type b | | | | | | | |
| IPV/OPV Polio | | | | | | | |
| PCV Pneumococcal Conjugate | | | | | | | |
| MMR Measles, Mumps, Rubella | | | | | | | |
| Measles | | | | | | | |
| Mumps | | | | | | | |
| Rubella | | | | | | | |
| Varicella Chickenpox | | | | | | | |

| | | | |
|-----------------------------|--|----------------------------------|--|
| Varicella - date of disease | | Varicella - positive screen date | |
|-----------------------------|--|----------------------------------|--|

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

Immunization date(s) MM/DD/YY

| | | | | | | | |
|--------------------------|--|--|--|--|--|--|--|
| HPV Human Papillomavirus | | | | | | | |
| Rota Rotavirus | | | | | | | |
| MCV4/MPSV4 Meningococcal | | | | | | | |
| Men B Meningococcal | | | | | | | |
| Hep A Hepatitis A | | | | | | | |
| Flu Influenza | | | | | | | |
| Other | | | | | | | |

Health care provider signature or stamp: _____

Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____

Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____