Oregon Certificate of Immunization Status
Oregon Department of Human Services, Immunization Program

Oregon law requires proof of immunization be provided or a religious or medical exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Department of Human Services, Immunization Program and may be released to the Department or the local Public Health Authority by the school or children's facility upon request of the Department. Vaccine history must include at least the month and year. Please list immunizations in the order they were received.

Complete for all | Up-to-date | Medical | Religious

Child's Last Name Apellido	First Primer Nombre	Middle Initial Segundo Nombre	Birthdate Fecha de Nacimiento
Mailing Address Dirección	City Ciudad	State Estado	Zip Code Codigo Postal
Parents' Names Nombre de los padres		Home Telephone Number Número de Teléfono	

Required Vaccines

Required Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus (DTaP, DT, Td, Tdap) ☐ Check here if child did **not** receive pertussis vaccine	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease / / (mm/dd/yy)					
Measles/Mumps/Rubella (MMR) *or* Measles vaccine only Mumps vaccine only Rubella vaccine only					
Hepatitis B (Hep B)					
Haemophilus Influenzae Type B (Hib) Required only under age 5 years					

I certify that the above information is an accurate record of this child's immunization history.

Signature* _____
Date

Update Signature _____
Date

Update Signature _____
Date

Update Signature _____
Date

*Parent, guardian, child at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

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Child's Last Name Apellido	First Primer Nombre	Middle Initial Segundo Nombre	Birthdate Fecha de Nacimiento

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Tetanus/Diphtheria Booster (Tdap or Td)					
Hepatitis A (Hep A)					
Pneumococcal (PCV7) (Children under 5 years)					
Meningococcal (MCV4) (Children 11-18 years)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature
- Physician's contact information, including phone number

For Immunity Exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature

Religious exemption:

I have read and understand the information in the brochure that I received. I am aware of the potential risks of my child being unimmunized, including being excluded from attending school during a disease outbreak. My child is being raised as an adherent to a religion the teachings of which are opposed to immunization and I request that my child be exempted from the following required immunizations:

Diphtheria	☐	Measles	☐
Tetanus	☐	Mumps	☐
Pertussis	☐	Rubella	☐
Polio	☐	Hepatitis B	☐
Varicella	☐	Hib	☐

Signature of Parent or Guardian _____ Date _____

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____
Date

Update Signature _____
Date

Update Signature _____
Date

Update Signature _____
Date