Rev. 07/2020

Georgia Department of Public Health

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CERTIFICATE OF IMMUNIZATION

VACCINE	DATE			DATE			DATE			DATE			DATE			DATE			Total Doses	Diagnosed	Serology+	History	Med. Exemption
	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY					
Required Vaccines for School or Child Care Attend Dnce																							
DTP,DTaP,DT,Td																			0				
Polio																			0				
Hepatitis B																			0				
Tdap																			0				
MCV4																			0				
HIB (Under Age 5)																			0				
PCV (Under Age 5)																			0				
Measles																			0				
Mumps																			0				
Rubella																			0				
Hepatitis A (Born on/after 1/1/06)																			0				
Varicella																			0				
Recommended Vaccines (For Information Only)																							
Rotavirus																			0				
HPV																			0				
Influenza																			0				
Td (booster)																			0				
Men-B																			0				

SAMPLE

Notes:

A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Certified by (Signature/Signature Stamp) Date of Issue

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