3147

ATTACHMENT
3

Name ______________________ Birthdate ______________________

Address ______________________ Parent or Guardian ______________________

______________________ Telephone ______________________

Race/Ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic Origin: ☐ Yes ☐ No

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

PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE

VACCINE Circle appropriate item	Enter month, day, and year each immunization will be given DOSES				
Diphtheria and Tetanus (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, Diphtheria and Acellular Pertussis (Tdap) (7th grade)	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		Titler
Varicella (Vaccine or Disease)	1 / /	2 / /	Rubella Serology Date		Titler
Meningococcal (MCV) (7th & 12th grade)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

X______________________

Signature (PLEASE CIRCLE - physician, nurse practitioner, physician's assistant, local Health Department)