

# **CERTIFICATE OF PREVIOUS IMMUNIZATION AND RECORDS OF DISEASES**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Sex : \_\_\_\_\_

## **1) Records of Immunization**

<b>Type of Immunization</b>	<b>Date of Vaccination</b>
DPT <sup>1)</sup> 1st	
DPT 2nd	
DPT 3rd	
DPT 4th	
DT <sup>2)</sup>	
TOPV <sup>3)</sup> 1st	
TOPV 2nd	
BCG	
Measles	
Rubella	
Hepatitis B 1st	
Hepatitis B 2nd	
Hepatitis B 3rd	

<sup>1)</sup>DPT: Diphtheria, Pertussis, Tetanus, <sup>2)</sup>DT: Diphtheria, Tetanus, <sup>3)</sup> TOPV: Trivalent oral polio vaccine

## **2) Records of Past History and Results of Antibody Titer**

<b>Name of Disease</b>	<b>Date of Infection</b>	<b>Serum Antibody Titer (Method, Titer, Date)</b>
Measles		
Mumps		
Rubella		
Varicella		

**This is to certify that these data come from our medical records.**