COMMONWEALTH OF KENTUCKY
PROVISIONAL IMMUNIZATION CERTIFICATE

Name of Child: ____ Birthdate: ______________
(Last) (First) (Middle)

Name of Parent of Guardian: ____

Address: ____
(Street) (City) (State) (Zip code)

DATES IMMUNIZATIONS WERE ADMINISTERED (Month/Day/Year)

Diphtheria, Tetanus, Pertussis*	**#1___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___**
Hib**	**#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___**
PCV (Pneumococcal)	**#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___**
Polio	**#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___**
Hepatitis B***	**#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ or Adult dose: #1 ___/___/___ #2 ___/___/___**
MMR (Measles, Mumps, Rubella)	**#1 ___/___/___ #2 ___/___/___**
Varicella	**#1 ___/___/___ #2 ___/___/___ or child has had chickenpox or zoster disease (X) ____**
Tdap	**#1 ___/___/___ or Td #1 ___/___/___ Meningococcal #1 ___/___/___**

*DTaP, DTP, or DT. **Hib not required at 5 years of age or more. ***Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age.

This child is not up-to-date at this time. This certificate is valid until ___/___/___, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

____ ____________________
(Signature of physician, APRN, PA, pharmacist, LHD administrator, or nurse designee) (Date)

____
(Name of Office or Licensed Healthcare Facility)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

EPID-230C (Rev 08/2010)