



# Oregon Certificate of Immunization Status, Page 2

## Oregon Health Authority, Immunization Program




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Child's Last Name First Middle Initial Birthdate

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Recommended Vaccines	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	Pneumococcal (PCV) (Only in children less than 5 years)					
	Meningococcal (MCV4, MPSV4)					
	Human Papilloma Virus (HPV) (9 years or older)					
	Influenza (Flu)					
	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 and date
- § Physician's contact information, including phone number

**For Immunity Documentation** (history of disease or positive titer): **Please submit a letter signed by a licensed physician stating:**

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

**Nonmedical Exemption:**

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- A health care practitioner
- The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

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 \_\_\_\_\_