

THE CHILDREN'S CENTER AT UCP
9 SMITHS LANE COMMACK, NY 11725
TEL.#: (631) 543-2338 FAX #: 543-5981

Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Date of Birth:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Parent/Guardian Name:			Parent/Guardian Day Phone:

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional

◆ **Required for School and Preschool**

● **Required for Preschool Only**

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age
◆ Hepatitis B (Hep B)				● Pneumococcal (PCV,PPV)				Hepatitis A (Hep A)			
	1				1				1		
	2				2				2		
	3				3			Meningococcal (MCV4, MPSV4)			
					4				1		
Hepatitis B (Hep B) Alternate schedule for teens				◆ Polio (IPV, OPV)				Human Papillomavirus (HPV)			
	1				1				1		
	2				2				2		
Rotavirus					3				3		
	1				4						
	2							Other			
	3										
◆ Diphtheria, Tetanus, Pertussis (DtaP, DTP, DT)				Influenza (most recent)							
	1										
	2										
	3			◆ Measles, Mumps, Rubella (MMR)							
	4				1						
	5				2						
Diphtheria, Tetanus, Pertussis (Tdap, Td)											
	1			◆ Varicella (chickenpox)							
	2				1						
● Haemophilus influenzae type b (Hib)					2						
	1										
	2										
	3										
	4										

I certify that the information provided here is correct and verifiable.

Signature of Parent or Guardian Date

↓ Stamp ↓

Typed or Printed Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

Signature of Licensed Health Care Provider (required) Date