



**CERTIFICATE OF IMMUNIZATION**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 SFN 16038 (Revised 05-2012)

Division of Disease Control  
 2635 East Main Ave. PO Box 5520  
 Bismarck, ND 58506-5520  
 800.472.2180 or 701.328.3386

**North Dakota law requires this form be completed\* and provided to the childcare facility or school.**

Child's Name (Last, First, Middle Initial):			Date of Birth:				
Parent's Name:			Telephone Number:				
Vaccine Type		Exemption Check type below <sup>€</sup>	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B	<input type="checkbox"/>					
Rotavirus	Rotavirus	<input type="checkbox"/>					
Hib	<i>Haemophilus influenzae</i> type B	<input type="checkbox"/>					
PCV	Pneumococcal conjugate	<input type="checkbox"/>					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis	<input type="checkbox"/>					
OPV/IPV	Polio	<input type="checkbox"/>					
MMR	Measles-Mumps-Rubella	<input type="checkbox"/>					
Varicella	Chickenpox	<input type="checkbox"/>			<b>History of Disease Date:</b>		
Hepatitis A	Hepatitis A	<input type="checkbox"/>					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	<input type="checkbox"/>					
MCV4	Meningococcal	<input type="checkbox"/>					
HPV	Human Papillomavirus	<input type="checkbox"/>					
Other		<input type="checkbox"/>					

**To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.**

Physician, Nurse, Local/State Health	Title	Date
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**If additional doses are added after initial signature, please initial dose and sign below.**

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

**My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Statement of Exemption to Immunization Law**

**In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.**

**Medical Exemption:** The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Physician Signature:	Date:
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<sup>€</sup>**Exemption:** (Indicate vaccine above)

(Please check one)  Religious  Philosophical  Moral  History of Disease

Parent/Guardian Signature	Date
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