

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO

Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____

Date of birth: _____

Parent/guardian: _____

Required vaccines

Immunization date(s) MM/DD/YY

Titer date*
MM/DD/YY

Hep B Hepatitis B								
DTaP Diphtheria, Tetanus, Pertussis (pediatric)								
Tdap Tetanus, Diphtheria, Pertussis								
Td Tetanus, Diphtheria								
Hib <i>Haemophilus influenzae</i> type b								
IPV/OPV Polio								
PCV Pneumococcal Conjugate								
MMR Measles, Mumps, Rubella								
Measles								
Mumps								
Rubella								
Varicella Chickenpox								

Varicella - date of disease		Varicella - positive screen date	
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*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus								
Rota Rotavirus								
MCV4/MPSV4 Meningococcal								
Men B Meningococcal								
Hep A Hepatitis A								
Flu Influenza								
Other								

Health care provider signature or stamp: _____

Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____

Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____