

Use required on or after July 1, 2015.

Tennessee Department of Health  
**CERTIFICATE OF IMMUNIZATION**

Child's Name (Last, first, middle, initials) \_\_\_\_\_ Birthdate (month/day) \_\_\_\_\_

Parent/Guardian Name (Last, first, middle, initials) \_\_\_\_\_

Please (please include area code and area code) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Section 1a. Religious Exemption**  
 Child's family or religious exemption is documented according to the Tennessee Department of Health website: <http://www.tn.gov/health/immunization>

**1b. Health Examination Documentation (if required)**  
 This child has been examined by \_\_\_\_\_ MD, DO, PA, Advanced Practice Nurse or Health Department \_\_\_\_\_

**1c. Check if needed**  
 Initial Screening  
 Update Screening

Unless specifically exempted by law, Tennessee law requires a certificate on file for each child 6 months of age through age 18 years who resides in Tennessee. Exempt certificates for this form and registration of requirements are in "The Summary of Immunization Requirements" (available at the Tennessee Department of Health website: <http://www.tn.gov/health/immunization>) and the "Tennessee Immunization Information System" (<http://www.tn.gov/health/immunization>).

VACCINE	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	DATE RECEIVED	
<b>Section 2a. Required Vaccines for School or Child Care Attendance (Dates Required)</b>																				
DTaP, DTaP, DT, Td																				
Poliomyelitis																				
Hepatitis B																				
Hepatitis A																				
Measles																				
Mumps																				
Rubella																				
Varicella																				
Tdap Booster																				
<b>Section 2b. Recommended Vaccines (Documentation Optional)</b>																				
Rotavirus																				
Influenza																				
Meningococcal ACWY																				
HPV																				

**Section 3. Provider Assessment (select one\*, not valid if blank)**

A) Temporary Certificate - Expires MM/DD/YYYY

B) Up to Date for Child Care Entry and <18 Months of Age

C) Complete for Child Care (Pre-School)

D) Complete K-8th Grade

E) Complete 7th Grade or Higher

Section 4. (Required) Printer or Standard Name, Address, Phone of Qualified Healthcare Provider (MD, DO, PA, Advanced Practice Nurse or Health Department)

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PH-4153 (Rev. 1/14)

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Valid

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