CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Each immunization date MM/DD/YY						**Titer date**
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* 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	

Recommended vaccines

	Each immunization date MM/DD/YY					
HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider
I have reviewed this immunization record

Signature: _____ Date: _____

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT
I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____ Date: _____

General Health Appraisal Form

Parent: *Please complete*

Child's Name: _____ **Birthdate:** _____

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

Diet: ❑ Breast Fed ❑ Formula: _____ ❑ Age Appropriate

❑ Special Diet: _____

❑ **Preventive creams/ointments/sunscreen** may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

_____ Date: _____

Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ ** B/P:** _____ ****Lead Level:** _____

Physical Exam: ❑ Normal ❑ Abnormal *(see explanation of significant health concerns:)*

Significant Health Concerns: ❑ None ❑ Reactive Airways Disease ❑ Seizures ❑ Diabetes ❑ Developmental Delays

❑ Vision ❑ Hearing ❑ Hospitalizations ❑ Severe Allergies ❑ Other *(dental, nutrition, behavior, etc.)* _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

_____

Current Medications/Special Diet: ❑ None ❑ Describe: _____

_____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

Immunizations: ❑ Up-to-date ❑ See attached immunization record ❑ Administered today: _____

_____

Signature:

Next Well Visit: ❑ Per AAP Guidelines* or ❑ Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

_____ _____

Signature of Health Care Provider (certifying form was reviewed) — Date

Office Stamp: *Or write Name, Address, Phone Number*

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule