THE CHILDREN'S CENTER AT UCPA of Greater Suffolk, Inc.

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 if Birth: Child's Sex: ☐ Male ☐ 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													
	1				◆ **Polio (IPV, OPV)**					**Human Papillomavirus (HPV)**			
	2					**1**					**1**		
Rotavirus						**2**					**2**		
	1					**3**					**3**		
	2					**4**							
	3									**Other**			
◆**Diptheria, Tetanus, Pertussis (DtaP, DTP, DT)**					**Influenza (most recent)**								
	1												
	2												
	3				◆ **Measles, Mumps, Rubella (MMR)**								
	4					**1**							
	5					**2**							
Diptheria, 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*

Return Completed form to Main Office