



**CERTIFICATE OF IMMUNIZATION**  
**NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
 SFN 16038 (Revised 09-2022)

Public Health Division, Immunization Unit  
 600 E Boulevard Ave, Dept 325  
 Bismarck, ND 58506-5520  
 800.472.2180 or 701.328.3386

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Type*	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B						
Rotavirus	Rotavirus						
Hib	<i>Haemophilus influenzae</i> type B						
PCV	Pneumococcal conjugate						
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis						
IPV/OPV	Polio						
MMR	Measles-Mumps-Rubella						
Varicella	Chickenpox						
Hepatitis A	Hepatitis A						
Td/Tdap	Tetanus-Diphtheria (and Pertussis)						
MCV4	Meningococcal ACYW-135						
HPV	Human Papillomavirus						
Men B	Meningococcal B						
Other							

**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:
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Update signature #2:

Physician, Nurse, Local/State Health:	Title:	Date:
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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) and to submit a signed Certificate of Immunization.

Parent/Guardian Signature:	Date:
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**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 (Med) Exemption:** (Indicate vaccine above, requires physician signature) 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.

**History of Disease (HD) Exemption:** (Indicate vaccine above, requires physician signature) To the best of my knowledge, the above named person has had prior infection with chickenpox disease as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:
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**Religious (Rel), Philosophical/Moral (PBE) Exemption:** (Indicate vaccine above, requires parental signature)

Parent/Guardian Signature:	Date:
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\* Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE