

**COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

**COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION**

| Vaccine  |  | Enter the month, day and year each immunization was given |  |  |  |  |                             |
|--|--|---|--|--|--|--|-----------------------------|
| Hep B  | Hepatitis B                                |   |  |  |  |  |                             |
| DTaP   | Diphtheria, Tetanus, Pertussis (pediatric) |   |  |  |  |  |                             |
| DT   | Diphtheria, Tetanus (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  | Measles                                    |   |  |  |  |  |                             |
| Mumps  | Mumps                                      |   |  |  |  |  |                             |
| Rubella  | Rubella                                    |   |  |  |  |  |                             |
| Varicella  | Chickenpox                                 |   |  |  |  | Healthcare Provider Documentation Date _____ | Lab Verification Date _____ |
| Vaccines recorded below this line are recommended. Recording of dates is encouraged. |  |   |  |  |  |  |                             |
| HPV  | Human Papillomavirus                       |   |  |  |  |  |                             |
| Rota   | Rotavirus                                  |   |  |  |  |  |                             |
| MCV4/MPSV4   | Meningococcal                              |   |  |  |  |  |                             |
| Hep A  | Hepatitis A                                |   |  |  |  |  |                             |
| TIV/LAIV   | Influenza                                  |   |  |  |  |  |                             |
| Other  |  |   |  |  |  |  |                             |

**THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER**

- A) Child Care Up to Date**  
Up to date through 6 months of age for Colorado School Immunization Requirements \_\_\_\_\_ Update Signature \_\_\_\_\_ Date \_\_\_\_\_
- B) Child Care Up to Date**  
Up to date through 18 months of age for Colorado School Immunization Requirements \_\_\_\_\_ Update Signature \_\_\_\_\_ Date \_\_\_\_\_
- C) Child Care/Pre-school/Pre-K\***  
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements \_\_\_\_\_ Update Signature \_\_\_\_\_ Date \_\_\_\_\_
- D) Complete for K–5th Grade**  
Up to date for K–5th Grade for Colorado School Immunization Requirements \_\_\_\_\_ Update Signature \_\_\_\_\_ Date \_\_\_\_\_

\* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

**HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)**

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Physician, nurse, or school health authority)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW  
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)**

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.  
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.**

**MEDICAL EXEMPTION:** 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.

**EXENCIÓN POR RAZONES MÉDICAS:** El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

*Medical exemption to the following vaccine(s):*

*La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):*

Hep B  DTaP  Tdap  Hib  IPV  PCV  MMR  VAR

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Physician (Médico)

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

**EXENCIÓN POR MOTIVOS RELIGIOSOS:** El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

*Religious exemption to the following vaccine(s):*

*Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):*

Hep B  DTaP  Tdap  Hib  IPV  PCV  MMR  VAR

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student/consenting minor  
(Padre, tutor, estudiante emancipado o consentimiento del menor)

**PERSONAL EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

**EXENCIÓN POR CREENCIAS PERSONALES:** Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

*Personal exemption to the following vaccine(s):*

*Exención por creencias personales de la(s) siguiente(s) vacuna(s):*

Hep B  DTaP  Tdap  Hib  IPV  PCV  MMR  VAR

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student/consenting minor  
(Padre, tutor, estudiante emancipado o consentimiento del menor)