



IMMUNIZATIONS IN PROGRESS

FOR PHYSICIANS AND
PUBLIC HEALTH NURSES ONLY

REQUIRED UNDER THE STATE IMMUNIZATION LAWS (Section 167.181 and Section 210.003, RSMo Cum. Supp. 1990) FOR SCHOOL, PRESCHOOL, DAY CARE AND NURSERY SCHOOL ATTENDANCE

THIS IS TO CERTIFY THAT	NAME OF CHILD (PRINT OR TYPE)
received the following immunization(s) on _____ MONTH/DAY/YEAR as required by State Immunization Laws	
<input type="checkbox"/> DIPHTHERIA	<input type="checkbox"/> TETANUS
<input type="checkbox"/> Hib	<input type="checkbox"/> VARICELLA
<input type="checkbox"/> RUBELLA	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> PERTUSSIS	<input type="checkbox"/> POLIO
<input type="checkbox"/> MEASLES	<input type="checkbox"/> MUMPS
<input type="checkbox"/> PNEUMOCOCCAL	
and is scheduled to return on _____ MONTH/DAY/YEAR for the following immunization(s) _____	
NOTE: This child is in compliance with Missouri Immunization Laws as long as he/she continues to receive the appropriate immunization(s) at the correct intervals according to the Department's Immunization Schedule.	
PHYSICIAN NAME (PRINT OR TYPE)	PHYSICIAN SIGNATURE
PUBLIC HEALTH NURSE	DATE
	CITY OR COUNTY OF ASSIGNMENT