IMMUNIZATION RECORD

NAME Jessica Price

BIRTHDATE 3-1-89

ALLERGIES _____

Your child must meet South Dakota's immunization requirements to be enrolled in school. Retain this document as proof of immunization.

IMMUNIZATION SCHEDULES

TABLE I Recommended Schedule for Normal Infants	TABLE II Schedule for Children Not Immunized in Early Infancy	TABLE III Schedule for Children Not Previously Immunized
AGE	**AGES 15 MONTHS - 6 YEARS**	**AGES 7 YEARS AND OLDER**
2 mo. DTP, TOPV	First Visit DTP, TOPV, MMR	First Visit Td, TOPV, MMR
4 mo. DTP, TOPV	2 mo. after 1st visit DTP, TOPV	2 mo. after 1st visit Td, TOPV
6 mo. DTP, ~~TOPV~~*	2 mo. after 2nd visit DTP, TOPV*	6-12 mo. after 2nd visit Td, TOPV
15 mo. MMR	6-12 mo. after 3rd visit or at school entry DTP, TOPV	Thereafter Td, repeat every 10 years
15-18 mo. DTP, TOPV	Age 14-16 yrs. Td: repeat every 10 yrs.	
4-6 yrs. DTP, TOPV	*Optional	
14-16 yrs. Td: repeat every 10 years		
*Optional		

Age intervals may be changed by your doctor to meet your child's needs.

(SD Dept. of Health, 5-82)

OTHER IMMUNIZATIONS/PROPHYLAXIS RECEIVED
Autres vaccinations/prophylaxies reçues

This space is provided to record immunizations/prophylaxis that are not required for entrance into any country but have been obtained by the traveler for additional health protection (immune globulin, malaria, measles, etc.)

Date	Vaccine/prophylactic drug Vaccin/médicament prophylactique	Dose	Physician's signature Signature du médecin
JUL 96	Hepatitis A	0.5ml IM	Steven C. Stocks, MD

How to Complete Your International Certificate of Vaccination

1. Enter your name and address on the cover of the booklet before presenting it to your physician.
2. At the beginning of the Yellow Fever Certificate, print your name on the first line, sign your name on the second line, indicate your sex, and indicate your date of birth in the following sequence: day, month, year. Example: 5 June 1956.
3. It is your responsibility to have the Yellow Fever Certificate validated with an "approved stamp." THE YELLOW FEVER CERTIFICATE IS NOT VALID WITHOUT AN "APPROVED STAMP."

INSTRUCTIONS TO PHYSICIANS

INFORMATION REQUESTED IN EACH SECTION MUST BE COMPLETED FOR THE SECTION TO BE VALID.

1. The dates are to be written with the day in arabic numerals, followed by the month in letters and the year in arabic numerals.
Example: 2 Jan. 1982
2. Vaccinations may be given by a licensed physician or under the direct supervision of a qualified medical practitioner. The WRITTEN signature of the physician or other person authorized by the physician must appear on the Certificate. A signature stamp is not acceptable.
3. If yellow fever immunization is required for your patient but is contraindicated on medical grounds, you should complete the "Medical Contraindication to Vaccination" statement indicating the nature of the contraindication.
4. It is strongly recommended that persons traveling abroad and those entering the United States be immune from measles by prior disease or vaccination.
5. There is a risk of acquiring MALARIA when traveling to parts of the Caribbean Central and South America, Africa, the Middle East, the Indian subcontinent, the Far East, and Oceania. For information on malaria prophylaxis, areas where malaria transmission occurs, recommended prophylactic drug regimens, and on preparing patients for international travel, contact your local or State Health Department or call the CDC's toll-free information service at 1-888-232-3228.

VACCINE		DATE GIVEN	DOCTOR OR CLINIC	MEDICAL NOTES [Mfg. & lot #]	DATE NEXT DUE
TOPV Trivalent Oral Polio Vaccine	1	6-7-89	WRCHC		
	2	10-4-89	BHFP Jo Detwiler PAC.		
	3	11-2-90	WRCHC		
	4	3/21/94	WRDOH		
	5			optional	
DTP/Td Diphtheria, Tetanus, Pertussis	1	6-7-89	WRCHC		
	2	10-4-89	BHFP Jo Detwiler PAC		
	3	2-7-90	WRCHC -		
	4	11-2-90	WRCHC		
	5	3/21/94	WRDOH		
MEASLES		11/2/90	#3 WRDOH 3/21/94		
RUBELLA			WRCHC		
MUMPS					
PPD		3/21/94	WRDOH		

PRESENT THIS RECORD AT EACH VISIT

INTERNATIONAL CERTIFICATE OF VACCINATION

AS APPROVED BY

THE WORLD HEALTH ORGANIZATION

CERTIFICAT INTERNATIONAL DE VACCINATION

APPROUVÉ PAR

L'ORGANISATION MONDIALE DE LA SANTE

Jessica Drake

TRAVELER'S NAME–NOM DU VOYAGEUR

ADDRESS–ADRESSE (Number–Numéro) (Street–Rue)

(City–Ville)

(County–Departement) (State–État)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

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