

WEST VIRGINIA PROVISIONAL CERTIFICATE OF IMMUNIZATION (VP-3 - PART A) West Virginia Department of Health and Human Resources Bureau for Public Health

Child's Name	-	First	<u>\$</u>	Middle	Date of Birth	Month Day	y Year	Parent or Legal Guardian	
Doctor: Part "A" of this form is used only if the child has received all required immunizations listed below. If not, see the reverse side.	Part "A" of this form is used If not, see the reverse side.	used only if t side.	he child ha	s received :	all required i	immunizations	s listed below.		
DTP/DTaP/DT:	Date	Date	Date	Date	Date	Series Complete: Yes	plete: Yes	No	
J 	,	!				Series Complete: Yes	plete: Yes	No	
Polio:	Date	Date	Date	Date	Date	!	-		
I i.	ı								
	Date	Date	Date	Date					
Prevnar:	Date	Date	Date	Date			T		
Hepatitis B:			***************************************			Tuberculin Test			
ניים לי	Date	Date	Date				Date		
MMR:						Results:	Positive	Negative	<u> </u>
	Date	Date							
∀aricella:			or history	Action to state common common to the common	o , etc., mooto,	Certified by:			
	Date	Date	of chickenpox		Date		Ph	Physician or Health Department	
All appropriate doses and dates including b dated in order for the child to attend school	doses and dat or the child to	es including attend schoo	birth date m	nust be ente	ered and the) certificate siç	gned below by a	All appropriate doses and dates including birth date must be entered and the certificate signed below by a physician or authorized person and dated in order for the child to attend school.	erson and
I have reviewed the records available and to the best of my knowledge the above named child has been adequately Diphtheria, Tetanus, Pertussis, Polio, Measles and Rubella as required by West Virginia Law for school attendance.	l the records a unus, Pertussi	available and s, Polio, Mea	to the best sles and Ru	of my knov ubella as re	vledge the a quired by W	bove named o /est Virginia L	child has been : .aw for school a	been adequately immunized against hool attendance.	inst
	Obviolan or Olini	C Name (Please	Print)		Phy	Physician or Authorized Signature	ed Signature	Date	
	Physician or Clinic Name (Please Print)	c Name (Please	Print)		۲ny	sician of Authoriz	en Signature	Cara	