

# DOMESTIC DEPENDENT ELEMENTARY AND SECONDARY SCHOOLS(DDESS) CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Domestic Dependent Elementary and Secondary Schools(DDESS) must meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the local medical authority, MUST be provided to school officials at time of initial registration for placement in the official school records of the student.**

(Please Print) Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Parent or Guardian \_\_\_\_\_

**Instructions for local medical authority:** In the spaces provided, write the dates (mo./day/yr.) of each immunization received. In the appropriate space, write the date of the last TB screening and the reaction/mm reading.

**Hepatitis B Vaccine:** Three doses: The second dose should be given at least one month after the first dose. The third dose should be given at least two months after the second and at least four months after the first.

Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_

**Diphtheria, Tetanus, and Pertussis Vaccine:** (Circle vaccine given.) Three doses given singly or in combination, at least one of which was administered after the 4th birthday and the last one within 10 years. (Td recommended at age 11-12 if more than five years have elapsed since the last DTaP/DPT/Td. Subsequent routine Td boosters are required every 10 yrs) . \*Pertussis vaccine is not required for individuals older than 6.

DTaP, DTP, Td \_\_\_\_\_  
Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_

**HIB (Haemophilus Influenza type B):** Two to four doses in infancy; 3- and 4-year-olds with NO record of HIB in infancy only require ONE dose. \*HIB immunization is not required for individuals 5 or older.

Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_

**Polio Vaccine** (Circle vaccine given): Three doses (oral or injected), last of which was administered after the 4th birthday.

IPV OPV \_\_\_\_\_  
Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_

**MMR (Measles, Mumps, and Rubella):** Two doses of live attenuated vaccine given singly or in combination, at least one of which was administered 28 days or more after the first dose, but second dose recommended after the 4th birthday.

Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_

**Varicella Vaccine:** One dose through the age of 12, two doses for those 13 or older (at least one month apart), or reliable history of the disease. **DATE CHILD HAD DISEASE PER PARENT REPORT:**

Mo./Day/Year \_\_\_\_\_ Mo./Day/Year \_\_\_\_\_ Mo./Year \_\_\_\_\_

**PPD:** Date: \_\_\_\_\_ Results: Negative  Positive  \_\_\_\_\_ mm. Preventive Medicine Referral Date: \_\_\_\_\_ INH Date: \_\_\_\_\_ - \_\_\_\_\_ **BCG:** Date: \_\_\_\_\_

**Chest Xray Date:** \_\_\_\_\_

**Other:** Specify vaccine (not to include TB Skin Test)  
Vaccine: \_\_\_\_\_ Date: \_\_\_\_\_ Vaccine: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the minimum immunization requirements have been completed and/or initiated. Immunizations are current until \_\_\_\_\_, when \_\_\_\_\_ immunization(s) is/are due.

\_\_\_\_\_  
Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious** \_\_\_ or **medical** \_\_\_ reasons must be supported by official documents from a church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): \_\_\_\_\_  
Reason: \_\_\_\_\_ Waiver Duration: \_\_\_\_\_

\_\_\_\_\_  
Signature and Stamp of Medical Authority/Date

