West Virginia Department of Health and Human Resources

Bureau for Public Health

WEST VIRGINIA PROVISIONAL CERTIFICATE OF IMMUNICATION (VP-3 – PART A)

Child's Name _____ Date of Birth _____ _____

Last First Middle Month Day 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.

DTP/DTaP/DT: _____ _____ _____ _____ _____ Series Complete: Yes_____ No _____
Date Date Date Date Date

Polio: _____ _____ _____ _____ _____ Series Complete: Yes_____ No _____
Date Date Date Date Date

Hib: _____ _____ _____ _____
Date Date Date Date

Prevnar: _____ _____ _____ _____
Date Date Date Date

Hepatitis B: _____ _____ _____
Date Date Date

MMR: _____ _____
Date Date

Varicella: _____ _____ or history _____
Date Date of chickenpox Date

Tuberculin Test _____
Date

Results: Positive _____ Negative _____

Certified by: _____
Physician or Health Department

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.

I have reviewed the records available and to the best of my knowledge the above named child has been adequately immunized against Diphtheria, Tetanus, Pertussis, Polio, Measles and Rubella as required by West Virginia Law for school attendance.

_____ _____ _____

Physician or Clinic Name (Please Print) Physician or Authorized Signature Date

Child's Name _____ Date of Birth _____ _____

Last First Middle Month Day Year Parent or Legal Guardian

DOCTOR: IF THE CHILD HAS NOT RECEIVED THE REQUIRED DOSES LISTED IN PART A, PLEASE COMPLETE PART B, SIGN AND DATE.

TEMPORARY MEDICAL EXEMPTION (VP-3 – PART B)

I CERTIFY THAT THE ABOVE-NAMED CHILD HAS RECEIVED THE IMMUNICATIONS LISTED BELOW AND HAS COMMENCED A SCHEDULE TO COMPLETE THE REQUIRED IMMUNIZATIONS. ADDITIONAL IMMUNIZATIONS ARE NOT MEDICALLY INDICATED AT THIS TIME.

TYPE VACCINE	DATE (MO/DA/YR)	DATE (MO/DA/YR)	DATE (MO/DA/YR)	DATE (MO/DA/YR)	DATE (MO/DA/YR)
DTaP					
Polio					
Prevnar					
HIB					
Hepatitis B					
MMR					
Varicella					
Tuberculin Test					

Or history of chickenpox _____

Date

Expiration Date (MO/DA/YR) _____

(SHOULD BE 15 DAYS AFTER NEXT APPOINTMENT)

Signed _____ Date_____

Physician or Health Official

_____

_____

West Virginia Department of Health and Human Resources, Bureau for Public Health
VP-3 Rev. 07/02
For use by schools, day care facilities and institutions.
Immunization and tuberculin test information may be completed by the provider
and the card incorporated into the permanent record at the time of entry.