Medical Certificate

I, Name_____

A medical doctor holding medical license No. _____

And is practicing at_____Hospital

Certify that _____is in good health, is free from contagious disease and has had the following vaccines.

Please tick ✓ if the child has had the following vaccines

_____ BCG Vaccine

_____ Hepatitis B Vaccine (3 Times)

_____ Diphtheria, Tetanus, Pertussis (3 Times)

_____ Polio Vaccine (3 Times)

_____ Polio Vaccine (First booster shot) (18 Month)

_____ Polio Vaccine (Second booster shot) (18 Month)

_____ MMR (Measles-Mumps-Rubella) Vaccine 1 Times (9-12 Month)

_____ MMR (Measles-Mumps-Rubella) Vaccine (First booster shot) (4-6 Year)

_____ Japanese Encephalitis (First time)

_____ Japanese Encephalitis (Second booster shot)

_____ Haemophilus Influenzae Vaccine (3 Times)

_____ Chickenpox Vaccine

_____ Hepatitis A Vaccine (2 Times)

_____ Typhoid Vaccine

_____ Influenza Vaccine

Congenital Disease _____

Allergies _____

Drug Allergy _____

Has the child experienced any serious illness? _____

_____

_____

Other information about the child's health

The child has developmental delay in _____

_____

_____

Remark_____

_____

_____

Signature _____M.D.

Date_____