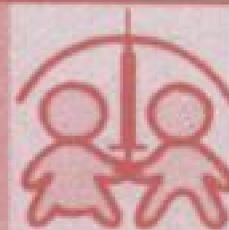
CERTIFICATE OF IMMUNIZATION

HMG/MoH, DoHS, Child Health Division

District Health Office...................



Please write with a ballpoint pen

(Name, ID Number, Address)

Sex:

Date of Birth :

Write date of dose given

Vaccine Type	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
BCG					
DPT					
HepB					
OPV					
Measles					
TT					
Others					

Complete Immunization ☐

Incomplete Immunization ☐

Certified By: