

STATE OF TEXAS, COUNTY OF DALLAS, DEPARTMENT OF HEALTH SERVICES, DIVISION OF PUBLIC HEALTH, IMMUNIZATION PROGRAM

THIS IS TO CERTIFY THAT THE FOLLOWING CHILDREN HAVE RECEIVED THE FOLLOWING VACCINATIONS:

NAME OF CHILD: [Faint text]

DATE OF BIRTH: [Faint text]

ADDRESS: [Faint text]

CITY: [Faint text]

STATE: [Faint text]

DATE OF VACCINATION: [Faint text]

VACCINATION RECEIVED: [Faint text]

NAME OF PHYSICIAN: [Faint text]

ADDRESS OF PHYSICIAN: [Faint text]

CITY OF PHYSICIAN: [Faint text]

STATE OF PHYSICIAN: [Faint text]

SIGNATURE OF PHYSICIAN: [Faint text]

DATE OF SIGNATURE: [Faint text]

NAME OF NURSE: [Faint text]

ADDRESS OF NURSE: [Faint text]

CITY OF NURSE: [Faint text]

STATE OF NURSE: [Faint text]

SIGNATURE OF NURSE: [Faint text]

DATE OF SIGNATURE: [Faint text]