INTERNATIONAL CERTIFICATE OF VACCINATION

Patient's Name ____________________

Date of Birth ____________________

To Whom it may concern.

This is to certify that the person has received the following vaccination.

BCG vaccine		8/28/2000
DPT vaccine	1st	12/12/2000
	2nd	2/18/2001
	3rd	3/16/2001
	4th	4/23/2002
Poliomeyelitis vaccine	1st	11/27/2001
	2nd	5/25/2002
Measles vaccine		8/27/2001
Rubella vaccine		10/29/2001
Measles-Rubella vaccine		4/2/2014
Japanese encephalitis vaccine	1st	9/6/2004
	2nd	10/13/2004
	3rd	3/29/2012
Mumpus vaccine	1st	7/3/2018
	2nd	8/3/2018
DT vaccine		3/17/2012

This Certified that the above is truth.

Date ____________________

Medical institution Kamata Station East Clinic

Address of the institution

4F,VORT KAMATA,5-15-1,Kamata,Ota-ku,Tokyo,JAPAN

Doctor's Signature ____________________