

# INTERNATIONAL CERTIFICATES OF VACCINATION

AS APPROVED BY  
THE WORLD HEALTH ORGANIZATION  
(EXCEPT FOR ADDRESS OF VACCINATOR)

# CERTIFICATS INTERNATIONAUX DE VACCINATION

APPROUVÉS PAR  
L'ORGANISATION MONDIALE DE LA SANTÉ

*Q* (SAUF L'ADRESSE DU VACCINATEUR)

TRAVELER'S NAME—NOM DU VOYAGEUR

*Doreen Jarrett*

ADDRESS—ADRESSE (Number—Numéro) (Street—Rue)

*5825 MERRICWOOD DRIVE*

(City—Ville)

*OAKLAND*

(County—Département)

*CALIFORNIA*

(State—État)

*U. S. A.*



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE

PHS-731 (REV. 1-74)

## INSTRUCTIONS TO TRAVELERS

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International Certificates of Vaccination or Revaccination are official statements verifying that proper procedures have been followed to immunize you against a disease which could be a threat to the United States and other countries. The Certificates are second in importance only to your passport in permitting uninterrupted international travel. **THEY MUST BE COMPLETE AND ACCURATE IN EVERY DETAIL**, or you may be detained at ports of entry.

When your itinerary is complete, you may obtain information on immunizations required or recommended for foreign travel from your local or State Health Department.

### How to Complete Your International Certificates of Vaccination

1. Enter your name and address on the cover of the booklet before presenting it to your physician.
2. On the Certificates required for your travel, print your name on the first line; sign your name on the second line; indicate your sex; and indicate your date of birth in the following sequence: day, month, year. Example: 5 June 1940.
3. Vaccination against smallpox and cholera may be given by any licensed physician in the United States. After the physician completes his part of the Certificate, take it to your local health department to be validated. Yellow fever immunization may be obtained only at a designated Yellow Fever Vaccination Center. The Certificate must be stamped with the official stamp of the Yellow Fever Vaccination Center.
4. It is your responsibility to have the Certificates validated with an "approved stamp." **THE CERTIFICATES ARE NOT VALID WITHOUT AN "APPROVED STAMP."**

## INSTRUCTIONS TO PHYSICIAN

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**INFORMATION REQUESTED ON EACH CERTIFICATE MUST BE COMPLETE FOR THE CERTIFICATE TO BE VALID.**

1. The space for primary vaccination against smallpox is to be used only when a person receives his vaccination for the first time. If unsuccessful, a new Certificate must be used for a repeat primary vaccination.
2. The dates on each Certificate are to be written with the day in arabic numerals, followed by the month in letters and the year in arabic numerals. Example: 1 Jan. 1971.
3. Vaccinations may be given by nurses and medical technicians if under the direct supervision of a qualified medical practitioner. The **WRITTEN** signature of the physician or other person authorized by him must appear on the Certificate. A signature stamp is not acceptable.
4. If smallpox vaccination is contraindicated on medical grounds, you should provide the patient with a written statement, on your letterhead, signed and dated, indicating the nature of the contraindication.
5. Information concerning official immunization requirements for international travel and the location of Yellow Fever Vaccination Centers in your area may be obtained from your local or State Health Department.

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**DO NOT THROW THIS BOOKLET AWAY. YOU MAY HAVE OCCASION TO USE THE CERTIFICATES FOR FUTURE TRAVEL AND AS A RECORD OF YOUR VACCINATION HISTORY.**

**INTERNATIONAL CERTIFICATE OF VACCINATION AGAINST SMALLPOX  
CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA VARIOLE**

This is to certify that  
Je soussigné(e) certifie que  
whose signature follows  
dont la signature suit

DWREN D SARRATT  
*Dwren D Sarratt*

sex Male  
date of birth  
né(e) le 11 Apr 31

has on the date indicated been vaccinated or revaccinated against smallpox with a freeze-dried or liquid vaccine certified to fulfill the recommended requirements of the World Health Organization.  
a été vacciné(e) ou revacciné(e) contre la variole à la date indiquée ci-dessous, avec un vaccin lyophilisé ou liquide certifié conforme aux normes recommandées par l'Organisation mondiale de la Santé.

Date	Show by "X" whether Indiquer par "X" s'il s'agit de	Signature, professional status, and address of vaccinator Signature, titre, et adresse du vaccinateur	Manufacturer and batch no. of vaccine Fabricant du vaccin et numéro du lot	Approved stamp Cachet autorisé
1a	Primary vaccination performed } <input type="checkbox"/> Primovaccination effectuée }			
1b	Read as successful } <input type="checkbox"/> Prise } Unsuccessful } <input type="checkbox"/> Pas de prise }			
2 24 Jan 1977	<input checked="" type="checkbox"/> Revaccination	Alameda County Health Care Service Agency 5 - Central District 499 - 5th Street Oakland, California 94607	<i>M. J. Kelly</i> #1707FM	OFFICIAL VACCINATION CALIFORNIA I B M No. 04 001 U. S. A.
3	<input type="checkbox"/> Revaccination			
4	<input type="checkbox"/> Revaccination			
5	<input type="checkbox"/> Revaccination			

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 3 years, beginning 8 days after the date of a successful primary vaccination\* or, in the event of a revaccination, on the date of that revaccination.

The approved stamp mentioned above must be in a form prescribed by the health administration of the country in which the vaccination is performed.

This certificate must be signed in his own hand by a medical practitioner or other person authorized by the national health administration; his official stamp is not an accepted substitute for his signature.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de trois ans commençant huit jours après la date de la primovaccination effectuée avec succès (prise) ou, dans le cas d'une revaccination, le jour de cette revaccination.

Le cachet autorisé doit être conforme au modèle prescrit par l'administration sanitaire du territoire où la vaccination est effectuée.

Ce certificat doit être signé de sa propre main par un médecin ou une autre personne habilitée par l'administration sanitaire nationale, un cachet officiel ne pouvant être considéré comme tenant lieu de signature.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

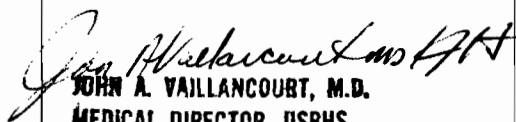
\*See item 1, instructions to Physicians.

INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST YELLOW FEVER  
 CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA FIÈVRE JAUNE

This is to certify that Je soussigné(e) certifie que DWREN D. SARRATT sex M sexe M

whose signature follows dont la signature suit *Dwren Sarratt* date of birth né(e) le 11 Apr 31

has on the date indicated been vaccinated or revaccinated against yellow fever.  
 a été vacciné(e) ou revacciné(e) contre la fièvre jaune à la date indiquée.

Date	Signature and professional status of vaccinator Signature et titre du vaccinateur	Manufacturer & batch number of vaccine Fabricant du vaccin et numéro du lot	Official stamp of vaccinating center Cachet officiel du centre de vaccination
1. FEB 28 1977	 <b>JOHN A. VAILLANCOURT, M.D.</b> <b>MEDICAL DIRECTOR, USPHS</b> <b>U.S. PUBLIC HEALTH SERVICE HOSPITAL</b> <b>SAN FRANCISCO, CALIFORNIA 941</b>	<u>1629 FK</u> <b>Wierrell-National</b> <b>Laboratories</b> <b>Division of</b> <b>Richardson-Merrill, Inc.</b>	
2.			

THIS CERTIFICATE IS VALID only if the vaccine used has been approved by the World Health Organization and if the vaccinating center has been designated by the health administration for the country in which that center is situated.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 10 years, beginning 10 days after the date of vaccination or, in the event of a revaccination, within such period of 10 years, from the date of that revaccination.

This certificate must be signed in his own hand by a medical practitioner or other person authorized by the national health administration; his official stamp is not an accepted substitute for his signature.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.  
 CE CERTIFICAT N'EST VALABLE que si le vaccin employé a été approuvé par l'Organisation mondiale de la Santé et si le centre de vaccination a été habilité par l'administration sanitaire du territoire dans lequel ce centre est situé.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de dix ans commençant dix jours après la date de la vaccination ou, dans le cas d'une revaccination au cours de cette période de dix ans, le jour de cette revaccination.

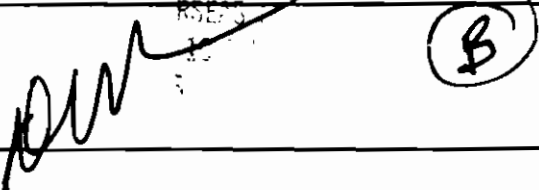
Ce certificat doit être signé de sa propre main par un médecin ou une autre personne habilitée par l'administration sanitaire nationale, un cachet officiel ne pouvant être considéré comme tenant lieu de signature.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

**INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST CHOLERA**  
**CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LE CHOLÉRA**

This is to certify that  
 Je soussigné(e) certifie que DWREN D. SARRAT sex Male  
 whose signature follows  
 dont la signature suit *Dwren D. Sarrat* date of birth 11 Apr 31  
 né(e) le

has on the date indicated been vaccinated or revaccinated against cholera.  
 a été vacciné(e) ou revacciné(e) contre le choléra à la date indiquée.

Date	Signature, professional status, and address of vaccinator Signature, titre, et adresse du vaccinateur	Approved stamp Cachet autorisé
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.
6.		6.
7.		7.

8.		8.
9.		9.
10.		10.
11.		11.
12.		12.

The vaccine used shall meet the requirements laid down by the World Health Organization.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 6 months, beginning 6 days after one injection of the vaccine or, in the event of a revaccination, within such period of 6 months, on the date of that revaccination.

The approved stamp mentioned above must be in a form prescribed by the health administration of the country in which the vaccination is performed.

This certificate must be signed in his own hand by a medical practitioner or other person authorized by the national health administration; his official stamp is not an accepted substitute for his signature.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

Le vaccin utilisé doit satisfaire aux normes formulées par l'Organisation mondiale de la Santé.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de six mois commençant six jours après une injection de vaccin ou, dans le cas d'une revaccination au cours de cette période de six mois, le jour de cette revaccination.

Le cachet autorisé doit être conforme au modèle prescrit par l'administration sanitaire du territoire où la vaccination est effectuée.

Ce certificat doit être signé de sa propre main par un médecin ou une autre personne habilitée par l'administration sanitaire nationale, un cachet officiel ne pouvant être considéré comme tenant lieu de signature.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.



**REMARKS CONCERNING VACCINATIONS—REMARQUES CONCERNANT LES VACCINATIONS**

Date	Notes	Physician's signature and address Signature et adresse du médecin

This information is to assist any physician called upon to treat an ill traveler.

Cette information est pour aider le médecin qui peut être appelé pour traiter un voyageur malade.

Date	Rh type Type Rh	Blood group Groupe sanguin	Name and address of physician—Signature et adresse du médecin

Name and address of person to notify in case of emergency.

Nom et adresse de la personne à aviser en cas d'urgence.

REMARKS concerning state of health, medical treatments, or known sensitivities:

REMARQUES concernant l'état de santé, traitements médicaux, ou sensibilités connues:

**OPHTHALMIC INFORMATION (Prescription Glasses)**

	Sphere	Cylinder	Axis	Prism	Base
(OD) Ocular Dexter	-1.25	-0.25	90		
(OS) Ocular Sinister	-1.50				

Add \_\_\_\_\_

Base Curve \_\_\_\_\_

Other PD 70/67

**INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST SMALLPOX  
CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA VARIOLE**

This is to certify that  
Je soussigné(e) certifie que Caren D. Barnett sex male  
whose signature follows Caren D. Barnett date of birth 11 Apr 51  
dont la signature suit Caren D. Barnett né(e) le 11 Apr 51  
has on the date indicated been vaccinated or revaccinated against smallpox.  
a été vacciné(e) ou revacciné(e) contre la variole à la date indiquée.

Date	Indicate by "X" whether Indiquer par "X" s'il s'agit de	Signature, professional status, and address of vaccinator Signature, qualité professionnelle, et adresse du vaccinateur	Approved stamp Cachet d'authentification
1a.	Primary vaccination performed Primovaccination effectuée <input type="checkbox"/>		1a.
1b.	Read as successful } <input type="checkbox"/> Prise Unsuccessful } <input type="checkbox"/> Pas de prise	<b>PERMANENTE MEDICAL GROUP OAKLAND, CALIF.</b> <i>[Signature]</i>	1b.
	<i>[Signature]</i> <input checked="" type="checkbox"/> Revaccination	<i>[Signature]</i>	<b>OFFICIAL VACCINATION CALIFORNIA 1966 SERIAL 801 U.S.A.</b>
7 June 1966	<input checked="" type="checkbox"/> Revaccination	<i>[Signature]</i> COMPLY WITH 18th W.C. SEMBLY REQUIREMENTS MAY 1965 EFFECTIVE JANUARY	<b>U.S. DEPARTMENT OF HEALTH OFFICE OF INTERNATIONAL AFFAIRS WASHINGTON, D.C.</b>
4.	<input type="checkbox"/> Revaccination	CHECK ONE - FREEZE DRIED VACCINE <input checked="" type="checkbox"/> - LIQUID VACCINE	4.
5. JUN 2 - 1967	<input checked="" type="checkbox"/> Revaccination	COMPLETE - ORIGIN <i>[Signature]</i>	5.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 3 years, beginning with the date of a successful primary vaccination or, in the event of a revaccination, on the date of that revaccination. The approved stamp mentioned above must be in a form prescribed by the health authorities of the country in which the vaccination is performed.

Any amendment of this certificate, or erasure, or failure to complete any part of it, shall render it invalid. **PHYSICIANS SIGNATURE**  
LA VALIDITÉ DE CE CERTIFICAT couvre une période de trois ans commençant huit jours après la date de la vaccination effectuée avec succès (prise) au, dans le cas d'une revaccination, le jour de la revaccination. Le cachet d'authentification doit être conforme au modèle prescrit par l'administration du pays où la vaccination est effectuée. Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions ci-dessus affectera sa validité.

**INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST YELLOW FEVER**  
**CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA FIÈVRE JAUNE**

This is to certify that **Owren D. Sarratt** sex \_\_\_\_\_  
 Je soussigné(e) certifie que \_\_\_\_\_ sexe \_\_\_\_\_  
 whose signature follows *Owren D. Sarratt* date of birth **4-11-31**  
 dont la signature suit \_\_\_\_\_ né(e) le \_\_\_\_\_

has on the date indicated been vaccinated or revaccinated against yellow fever.  
 a été vacciné(e) ou revacciné(e) contre la fièvre jaune à la date indiquée.

Date	Signature and professional status of vaccinator Signature et qualité professionnelle du vaccinateur	Origin and batch number of vaccine Origine du vaccin employé et numéro du lot	Official stamp of vaccinating center Cachet officiel du centre de vaccination
1. <b>2 MAY 1966</b>	<b>Thomas M. Gary, M. D.</b> Chief, OPD <i>E. M. ...</i> U. S. Public Health Service Hospital 15th Avenue and Lake Street San Francisco, California 94118	<b>National Drug Co.</b> <b>Philadelphia, Pa.</b>  <b>#6263</b>	1.
2.			2.

THIS CERTIFICATE IS VALID only if the vaccine used has been approved by the World Health Organization and if the vaccinating center has been designated by the health administration for the country in which that center is situated.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of *10* years, beginning 10 days after the date of vaccination\* or, in the event of a revaccination, within such period of *10* years, from the date of that revaccination.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

CE CERTIFICAT N'EST VALABLE que si le vaccin employé a été approuvé par l'Organisation Mondiale de la Santé et si le centre de vaccination a été habilité par l'administration sanitaire du territoire dans lequel ce centre est situé.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de six ans commençant dix jours après la date de la vaccination ou, dans cas d'une revaccination au cours de cette période de six ans, le jour de cette revaccination.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

\* See page 11, item 4.

**INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST CHOLERA**  
**CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LE CHOLÉRA**

This is to certify that / Je soussigné(e) certifie que Owren D. SARRATT sex / sexe male

whose signature follows / dont la signature suit Owren D. Sarratt date of birth / né(e) le 11 Apr 31

has on the date indicated been vaccinated or revaccinated against cholera.  
 a été vacciné(e) ou revacciné(e) contre le choléra à la date indiquée.

Date	Signature, professional status, and address of vaccinator Signature, qualité professionnelle, et adresse du vaccinateur	Approved stamp Cachet d'authentification
26/9/65	Cholera # 1 0.5 cc <i>J. H. Stokeman M.D.</i>	OFFICIAL VACCINATION 1. CALIFORNIA IBM No. 04 001 U. S. A.
3/27/65	Cholera # 2 1.5 cc <i>J. H. Stokeman M.D.</i>	
2.	PERMANENTE MEDICAL GROUP OAKLAND, CALIF <i>Brady, M. N.</i>	OFFICIAL VACCINATION 2. CALIFORNIA IBM No. 04 001 U. S. A.
3. 12/20/65	Cholera # 1.0 cc <i>J. H. Stokeman M.D.</i> <i>H. K. Wierzbicki</i>	OFFICIAL VACCINATION 3. CALIFORNIA IBM No. 04 001 U. S. A.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 6 months, beginning 6 days after the first injection of the vaccine or, in the event of a revaccination within such period of 6 months, on the date of that revaccination.




The approved stamp mentioned above must be in a form prescribed by the health administration of the country in which the vaccination is performed.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de six mois commençant six jours après la première injection du vaccin ou, dans le cas d'une revaccination au cours de cette période de six mois, le jour de cette revaccination.

Le cachet d'authentification doit être conforme au modèle prescrit par l'administration sanitaire du territoire où la vaccination est effectuée.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

Date	Signature, professional status, and address of vaccinator Signature, qualité professionnelle, et adresse du vaccinateur	Approved stamp Cachet d'authentification
4. 18/april/66	Cholera B 1.0 cc <i>[Handwritten signature]</i> PERMANENTE MEDICAL	OFFICIAL VACCINATION 4. CALIFORNIA IBM No. 04 001 U. S. A.
5. Oct 18 1966	GROUP OAKLAND CALIF. <i>[Handwritten signature]</i> Cholera vaccine Mankoff CHOLERA # BOON MEDICAL SERVICES	5.  MEDICAL DEPARTMENT 6. Contract NBY 41405 Saigon
7. APR 21 1967	<i>[Handwritten signature]</i> <del>...</del>	
8. 17/Aug/67	0.5 cc <i>[Handwritten signature]</i> MEDICAL DEPARTMENT RMK - BNI Contract NBY 41405 Saigon - Vietnam	8.  MEDICAL SERVICES CERTIFIED IMMUNIZATION 9.
9.		
10.		10.
11.		11.
12.		12.

## INSTRUCTIONS TO PHYSICIANS

1. Information requested on each certificate must be complete for the certificate to be valid.
2. The space for primary vaccination against smallpox is to be used only when a person receives his vaccination for the *first* time. If unsuccessful a new certificate must be used for a repeat primary vaccination.
3. The dates on each certificate are to be written with the day in arabic numerals, followed by the month in letters and the year in arabic numerals. Example: October 1, 1959, should be written 1/Oct./59.
4. Vaccinations may be performed by a nurse or medical technician if under a physician's direct supervision. The physician's *written* signature must appear on the certificate; signature stamp is not acceptable.
5. If vaccination is contraindicated the physician should provide the person with a written opinion, which port health authorities *may* take into account.
6. Official immunization requirements for international travel and the list of designated yellow fever vaccination centers in the United States are contained in the booklet "Immunization Information for International Travel," PHS No. 384, on sale at the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Changes in requirements may be obtained from local or State health departments.
7. Additional information concerning certificates and immunization requirements may be obtained from the Epidemiology and Domestic Operations Branch, Division of Foreign Quarantine, U.S. Public Health Service, Washington 25, D.C.

## INSTRUCTIONS TO THE TRAVELER

1. Properly complete the cover sheet of this booklet before presenting it to your physician.
2. It is the responsibility of the traveler to have the "*approved stamp*" applied to the smallpox vaccination certificate or the cholera vaccination certificate. The certificate is not *valid* without the stamp and may not be accepted when required in international travel.

In the United States the stamp is that of the local or State Health Officer of the area in which the immunizing physician practices. The certificate may be mailed to the Health Officer for this service if time permits its return. If mailed enclose a self-addressed, stamped envelope to ensure return.

Other "*approved stamps*" are (1) the stamp of the Department of Defense; (2) the stamp assigned to official Yellow Fever Vaccination Centers; (3) the seal of the Public Health Service; (4) the special "S-C" stamp approved by the Public Health Service for Smallpox and Cholera Vaccination Certificates.

3. When yellow fever vaccination is needed for international travel it must be received at a designated center. The list of designated centers in the United States is contained in the booklet "Immunization Information for International Travel," PHS No. 384.
4. The yellow fever vaccination certificate when required by India, Pakistan, or Ceylon may not become valid in some instances until the 12th day after vaccination.
5. Immunization requirements—see items 6 and 7, page 10.
6. Travelers revaccinated against cholera or yellow fever during the period of validity of a current vaccination certificate should retain the old certificate for a period of 6 days in the case of cholera and 12 days for yellow fever.

11. The information which follows is a record of other immunizations which the traveler has obtained as an additional health protection for international travel. These immunizations are *not* usually required for entrance by any country. Space is also provided for a personal health record in case of illness or accident while traveling abroad.

**OTHER IMMUNIZATIONS (Typhus, Typhoid-Paratyphoid, Plague, Poliomyelitis, Tetanus, etc.)**

Date	Vaccine	Dose	Physician's Signature
1-12-65	Tetanus B	0.5cc	M. H. Johnson M.D.
1-12-65	Typhus I	0.5cc	M. H. Johnson M.D.
3-12-65	Typhoid	0.5cc	J. S. Hayashida (K.N.)
3-22-65	Paratyphoid	0.5cc	H. Phillips M.D.
4-1-65	scaris	0.5cc	C. Garrison M.D.
2/18/65	Typhus II	0.5cc	C. Garrison M.D.
27 Apr 65	Plague #1	0.5cc	Albert G. Clark M.D.
27 Apr 65	Plague #1	0.5cc	Albert G. Clark M.D.
4 May 65	Plague #2	1.0 cc	Albert G. Clark M.D.
4 May 65	Polio (Oral) <sup>18</sup> Trivalent	2.0cc	Albert G. Clark M.D.

9-2-65	Tetanus B	0.5cc	M. H. Johnson M.D.
11-16-65	Plague #1	1.0cc	M. H. Johnson M.D.
3-4-66	Typhus B	1.0cc	M. H. Johnson M.D.
3-4-66	Plague #1	1.2cc	M. H. Johnson M.D.
4-20-66	trivalent oral	2cc	MARIO A. STANISLAO, M.D. Bradingue
4-20-66	Diph-Tet B	0.5cc	MARIO A. STANISLAO, M.D. Bradingue
4-22-66	Flu (Asian)	1cc	MARIO A. STANISLAO, M.D. Bradingue
4-26-66	Typhoid Paratyphoid	0.5cc	MARIO A. STANISLAO, M.D. Bradingue
7 Sept 66	Plague	0.5cc	DR. COREY M. B. [Signature]
MAR 3 67	PLAGUE #1	0.5cc	[Signature]
APR 18 1967	TYPHUS #1	1cc	[Signature]
APR 28 1967	TYPHOID #1	BOOSTER	James D. [Signature]
SEP - 4 1967	PLAGUE #1	BOOSTER	James D. [Signature]



**REMARKS CONCERNING VACCINATIONS—REMARQUES CONCERNANT LES VACCINATIONS**

Date	Notes	Physician's signature and address Signature et adresse du médecin

This information is to assist any physician called upon to treat an ill traveler.

Cette information est pour aider le médecin qui peut être appelé pour traiter un voyageur malade.

Date	Rh type type Rh	Blood group Groupe sanguin	Name and address of physician—Signature et adresse du médecin

Name and address of person to notify in case of emergency.

Nom et adresse de la personne à aviser en cas d'urgence.

REMARKS concerning state of health, medical treatments or known sensitivities:  
REMARQUES concernant l'état de santé, traitements médicaux, ou sensibilités connues:

GLASSES	Sphere—	Cylinder—	Prism—
O. D.—			
O. S.—			
ADD—			
NOTES—			

*De*

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