



FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; rules 64D-3.046, 65C-20.011, Florida Administrative Code

_____	_____	_____	_____
LAST NAME	FIRST NAME	MI	DOB (MO/DA/YR)
PARENT OR GUARDIAN	CHILD'S SS# (optional)	STATE IMMUNIZATION ID# (optional)	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See "Immunization Guidelines Florida Schools, Child Care Facilities and Family Day Care Homes" for information and instructions on form completion. Guidelines are available at: http://us/disease_ctrl/immune/schoolguide.pdf.

VACCINE	DOE CODE	Dose 1 MO/DA/YR	Dose 2 MO/DA/YR	Dose 3 MO/DA/YR	Dose 4 MO/DA/YR	Dose 5 MO/DA/YR
DTaP/DTP	A	_____	_____	_____	_____	_____
DT	B	_____	_____	_____	_____	_____
Td/Tdap	C	_____	_____	_____	_____	_____
Polio	D	_____	_____	_____	_____	_____
Hib	E	_____	_____	_____	_____	_____
MMR (Combined) (Separate)	F	_____	_____	_____	_____	_____
	G, H,	<i>Measles (dose 1)</i>	<i>Measles (dose2)</i>	<i>Mumps (dose 1)</i>	<i>Mumps (dose 2)</i>	_____
	I	<i>Rubella (dose 1)</i>	<i>Rubella (dose 2)</i>	_____	_____	_____
Hepatitis B	J	_____	_____	_____	_____	_____
Varicella	K	_____	_____	_____	_____	_____
Varicella Disease	L	_____	_____	_____	_____	_____
		Year	_____	_____	_____	_____
PneumoConju		_____	_____	_____	_____	_____

**Select appropriate box(es)
Certificate of Immunization for K-12**

Part A-Complete

Part A (Immunizations are complete for school entry and attendance and meet requirements for kindergarten and/or 7th grade {and for grades kindergarten through 12.} I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance as documented above.) DOE Code 1

Temporary Medical Exemption **Expiration date:** _____

Part B-Temporary

Part B (For children in day care, family day care homes, preschool and kindergarten grades through 12 who are incomplete for immunization in Part A) **Invalid without expiration date.** DOE Code 2

Permanent Medical Exemption

Part C-Permanent

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.) DOE Code 3 _____

I certify the physical condition of this child is such that immunization(s) as indicated in Part C above is medically contraindicated.

Physician or Clinic Name

Physician or
Authorized Signature: _____
Issued By: _____
Date: _____

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<u>PATIENT</u>	<u>TEST</u>		<u>01/01/2006</u>
Last Name	First Name	MI	DOB
<u>MOM PATIENT</u>		<u>9900001032</u>	
Parent or Guardian	Child's SS# (optional)	State Immunization ID#	

Directions:

* For additional information: See Immunization Guidelines for School and Child Care Facilities for information and instructions on form completion and immunization requirements. Guidelines are updated annually and are available from the local county health department.

VACCINE	DOE CODE	Dose 1 MO/DA/YR	Dose 2 MO/DA/YR	Dose 3 MO/DA/YR	Dose 4 MO/DA/YR	Dose 5 MO/DA/YR
DTaP/DTP	A	_____	_____	_____	_____	_____
DT	B	_____	_____	_____	_____	_____
Td/Tdap	C	_____	_____	_____	Booster	_____
Polio	D	_____	_____	_____	_____	_____
HIB	E	_____	_____	_____	_____	_____
MMR (Combined)	F	_____	_____	_____	_____	_____
(Separate)	G,H	_____	_____	_____	_____	_____
		<i>Measles (dose 1)</i>	<i>Measles (dose 2)</i>	<i>Mumps (dose 1)</i>	<i>Mumps (dose 2)</i>	
	I	_____	_____	_____	_____	_____
		<i>Rubella (dose 1)</i>	<i>Rubella (dose 2)</i>			
Hepatitis B	J	_____	_____	_____	_____	_____
Varicella	K	_____	_____	_____	_____	_____
Varicella Disease	L	_____	_____	_____	_____	_____
		<i>Year</i>				
PneuConju		_____	_____	_____	_____	_____

Certificate of Immunization for K-12

PART A (Immunizations are complete for school entry and attendance for grades kindergarten through 12.) DOE Code 1
I have reviewed the records available, and to the best of my knowledge, the above named child has been adequately immunized for school attendance as documented above.

Physician or Clinic Name: BUREAU OF IMMUNIZATION
2585 MERCHANTS ROW BLVD
TALLAHASSEE, FL 32399

Physician or
Authorized Signature: TEST DOCTOR
Electronic Certification: MD4N6GWBLG9
Date: 07/03/2007
Issued By: TEST USER

