



## FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; Rule 64D-3.046, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MM/DD/YY)
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 DH Form 150-615, Immunization Guidelines - Florida Schools, Childcare Facilities and Family Daycare Homes (July 2010) for information and instructions on form completion. Guidelines are available at: [www.immunizeflorida.org/schoolguide.pdf](http://www.immunizeflorida.org/schoolguide.pdf).

VACCINE	DOE CODE	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY	Dose 3 MM/DD/YY	Dose 4 MM/DD/YY	Dose 5 MM/DD/YY
DTaP/DTP	A	_____	_____	_____	_____	_____
DT	B	_____	_____	_____	_____	_____
Tdap	P	_____	_____	_____	_____	_____
Td	Q	_____	_____	_____	_____	_____
Polio	D	_____	_____	_____	_____	_____
Hib	E	_____	_____	_____	_____	_____
MMR (Combined) (Separate)	F	_____	_____	_____	_____	_____
	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	_____	_____	_____	_____	_____
PneumoConju	N	<i>Year</i>	_____	_____	_____	_____

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

**Part A-Complete**

- DOE Code 1: Immunizations are complete K-12 (Excluding 7<sup>th</sup> grade/middle school requirements)
- DOE Code 8: Immunizations are complete for 7<sup>th</sup> grade

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.

**Temporary Medical Exemption**

Expiration date: \_\_\_\_\_

**Part B-Temporary**

**Part B** (For children in daycare, family daycare homes, preschool, kindergarten and grades 1 through 12 who are incomplete for immunizations in Part A) **Invalid without expiration date.** DOE Code 2

I certify that the above named child has received the immunizations documented above and has commenced a schedule to complete the required immunization. Additional immunizations are not medically indicated at this time.

**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 immunizations as indicated in Part C above are medically contraindicated.

Physician or Clinic Name: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician or  
 Authorized Signature: \_\_\_\_\_  
 Issued By: \_\_\_\_\_  
 Date: \_\_\_\_\_