Florida HEALTH

FloridaShots

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/YYYY)
PARENT OR GUARDIAN	CHILD'S SS# (Optional)	STATE IMMUNIZATION ID#	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- For additional information: See *Immunization Guidelines—Florida Schools, Childcare Facilities and Family Daycare Homes* for information and instructions on form completion and immunization requirements. Guidelines are available at: www.ImmunizeFlorida.org/schoolguide.pdf.

VACCINE		DOE CODE	Dose 1 MM/DD/YYYY	Dose 2 MM/DD/YYYY	Dose 3 MM/DD/YYYY	Dose 4 MM/DD/YYYY	Dose 5 MM/DD/YYYY
DTaP/DTP		A					
DT		B					
Tdap		P					
Td		Q					
Polio		D					
Hib		E					
MMR	(Combined)	F					
	(Separate)	G, H					
			Measles (dose 1)	*Measles (dose 2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
		I					
			Rubella (dose 1)	*Rubella (dose 2)*			
Hepatitis B		J					
Varicella		K					
Varicella Disease		L					
			Year				
PneumoConjugate		N					

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

Part A-Complete

☐ DOE Code 1: Check box if immunizations are complete for kindergarten entry

☐ DOE Code 8: Check box if immunizations are complete for 7th 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

☐ DOE Code 2 (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.**

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

(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: _____