

SHOT



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, | 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 | _____ | _____ | _____ | _____ | _____ |
| PneumoConju | Year | _____ | _____ | _____ | _____ | _____ |

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: _____

(See back)

* Physical (good 2 yrs.)



Name of Child (Last, First, Middle) _____ Birth Date _____

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date:
(Exam must be within one year of enrollment)

Month _____ Day _____ Year _____

* Date
↑

Screening Results:

Height: _____ Weight: _____ BMI%: _____ BP: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

| | | | | | | | |
|--------------------------|-----------------|----------------|-----------------------------------|-----------------|---------------------------------|---------------------------------|-----------------------------------|
| Vision - Without Glasses | Right 20/ _____ | Left 20/ _____ | Passed <input type="checkbox"/> | Hearing - Right | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |
| Vision - With Glasses | Right 20/ _____ | Left 20/ _____ | Failed <input type="checkbox"/> | Hearing - Left | Passed <input type="checkbox"/> | Failed <input type="checkbox"/> | Referred <input type="checkbox"/> |
| | | | Referred <input type="checkbox"/> | | | | |

| | | | |
|-------------------------------|---------------------------------|-----------------------------------|-----------------|
| Gross dental (teeth and gums) | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |
| Head/scalp/skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |
| Eyes/Ears/Nose/Throat | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |
| Chest/Lungs/Heart | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |
| Abdomen | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |
| Postural assessment | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Refer/Tx: _____ |

TB risk assessment done (Please review Targeted Testing Guidelines listed below.)

This child has the following problems that may impact the educational experience:

- Vision Hearing Speech/Language Physical Social/Behavioral Cognitive

Specify: _____

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in school activities including physical education.
 This child may participate in school activities including physical education with the following restriction/adaptation:
 (Specify reason and restriction) _____

| | | |
|---|----------------|---------------------------------|
| Signature/Title of Health Care Provider | Date | Address (Please print or stamp) |
| | ____/____/____ | _____ |
| Name (Please print or stamp) | _____ | |

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. Do not record administration of any TB test or related information on this form.

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work up or refer for TB disease evaluation.