FLORIDA DEPARTMENT OF HEALTH

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.

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)	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*				
PneumoConju	N					

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

Part A-Complete

☐ DOE Code 1: Immunizations are complete K-12 (Excluding 7th grade/middle school requirements)

☐ DOE Code 8: 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**

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: _____

DH 680 (Jul 2010) Stock Number: 5740-000-0680-6

FLORIDA DEPARTMENT OF HEALTH

FloridaShots keeping shots in check

RELIGIOUS EXEMPTION FROM IMMUNIZATION

Exención Religiosa Para La Inmunización

Eksepsyon Pou Kwayans Relijyon Pou Pa Nan Pran Piki Ak Vaksen

Child's Name (printed) Nombre Del Niño (con letra de imprenta) Non Timoun Nan (an gran karaktè)	**Date of Birth** Fecha De Nacimiento Dat Li Te Fèt	**Child's SS# (optional)** Número De Seguro Social Del Niño (opcional) Nimewo Sekirite Sosyal Timoun Nan (si ou vie)	**Name of Parent or Guardian** Nombre Del Padre O Guardián Non Paran Oubyen Moun Ki Reskonsab Li Ya
	____/____/____	____-____-____	

(English) I am the parent or legal guardian of the above-named child. Immunizations are in conflict with my religious tenets or practices. Therefore, I request that my child be enrolled in school, preschool, child day care facilities, or family day care homes without immunizations required by sections 1003.22, F.S., 402.305, F.S., and 402.313, F.S.

The presence of any of the communicable diseases for which immunization is required by the Department of Health in Florida schools, preschools, child day care facilities, or family day care homes shall permit the county health department director or administrator or the State Health Officer to declare a communicable disease emergency. Those children identified as not being immunized against the disease for which the emergency has been declared shall be temporarily excluded from the facility by the district school board or governing authority until such time as is specified by the county health department director or administrator.

(Spanish) Yo soy uno de los padres o el guardián legal del niño mencionado anteriormente. Las inmunizaciones están en conflicto con mis principios o prácticas religiosas. Por lo tanto, pido que mi hijo se matricule en el colegio, preescolar, guardería infantil o servicios de cuidado para familias sin las inmunizaciones requeridas por las secciones 1003.22, F.A., 402.305, F.S., y 402.313, F.S.

La presencia de cualquier enfermedad contagiosa para la cual el Departamento de Salud en los colegios, preescolares, guarderías infantiles o servicios de cuidado para familias de la Florida requiere inmunización permitirá que el director o el administrador del departamento de salud del condado o el oficial de salud estatal declare una emergencia de enfermedad contagiosa. Aquellos niños que sean identificados como no inmunizados contra la enfermedad para la cual se ha declarado la emergencia serán excluidos temporalmente de las instalaciones por parte de la junta del distrito escolar o las autoridades gobernantes hasta que el director o el administrador del departamento de salud del condado lo especifique necesario.

(Creole) Mwen menm se paran oubyen moun ki reskonsab devan lalwa timoun sa ke nou sot baw non li ya piwo wa. Sa yo ap fè nan san yo tankou piki, seròm ak vaksen pa mache ak prensip oubyen ak pratik ki gen nan legliz mwen yan. Poutèt sa, mwen mande ke timoun mwen yan enskri nan lekòl, lekòl matènèl, jaden danfan, oubyen kote yo fè gadri pou timoun, san ke yo pa bezwen pran vaksen yo jan atik 1003.22, F.S., 402.305, F.S., ak 402.313, F.S. yo mandel.

Prezans nenpòt ki maladi kontajyez ki bezwen pou moun nan pran piki ak vaksen kan mèm dwe rekòmande pa Sèvis Sante ki nan lekòl yo ki anndan eta Florid la, lekòl matènèl, kote ke yo fasilite swen pou timoun, oubyen nan kay fanmi ki ap bay swen yo pou ka pèmèt direktè oubyen administratè Sante zòn nan oubyen ofisye sante eta deklare ke ou genyen you maladi kontajyez ki gen ijans. Timoun sa yo ke yo idanfifye ki pa te pran piki, seròm ak lòt bagay nan san kont maladi kontajyez ke yo deklare ki gen ijans lan nou pral mete yo deyò pou you ti tan jiskaske direktè ya oubyen administratè sante zòn nan deklare ke lè ya rive pou yo tounen.

Electronic Signature of Parent or Guardian Firma del Padre o Guardián Siyati Paran Oubyen Moun Ki Reskonsab Li	____/____/____ **Date** Fecha Dat
Electronic Signature of Director/Administrator	____/____/____ **Date**

County Health Department

Florida HEALTH

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ _____ _____
Signature of Parent/Guardian Date

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.