


# SUDBURY PARK & RECREATION

## PHYSICAL & IMMUNIZATION REQUIREMENTS

**EACH PARTICIPANT MUST PROVIDE A RECORD OF THEIR MOST RECENT PHYSICAL EXAM AND IMMUNIZATIONS DATED WITHIN THE PAST 24 MONTHS. PLEASE SEND IN YOUR CHILD'S PHYSICAL AND IMMUNIZATION FORM PROVIDED BY YOUR DOCTOR'S OFFICE. WITHOUT UPDATED MEDICAL FORMS, YOUR CHILD WILL NOT BE ALLOWED TO PARTICIPATE.**



**FLORIDA CERTIFICATION OF IMMUNIZATION**  
Legal Authority: Sections 1005.26-1005.29, 402.111, Florida Statutes; Rule 600-0.040, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MM/DD/YY)
PARENT OR GUARDIAN	CHILD'S SSN (optional)		STATE IMMUNIZATION ID# (optional)

**Directions:**

- Enter an appropriate dose and date below.
- Signed date appropriate certificate (A, B, or C) on form.
- See DH Form 150-015, Immunization Guidelines - Florida Schools, Child-care Facilities and Family Day-care Homes (July 2013) for information and instructions on form completion. Guidelines available at: [www.immunize4kids.org/schools/ide.pdf](http://www.immunize4kids.org/schools/ide.pdf)

VACCINE	DOSE 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/IP	A					
DT	B					
Tdap	F					
Td	G					
Polio	D					
Hib	E					
MM (Combined)	F					
MM (Separate)	G, H					
		Mening (dose 1)	Mening (dose 2)	Mening (dose 3)	Mening (dose 4)	Mening (dose 5)
		Acellula (dose 1)	Acellula (dose 2)			
Hepatitis B	J					
Varicella	K					
Varicella-Zoster	L					
PneumoCocn	M					

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

**Part A-Complete**

DOB Code 1: Immunizations are complete K-12 (Excludes F: preschool school requirements)

DOB Code A: Immunizations are complete K-12

I have reviewed the records available, and to the best of my knowledge, the above named child has previously been immunized for some or all of the following (do not check if 0 doses):

**Temporary Medical Exemption**      Expiration date: \_\_\_\_\_

**Part B-Temporary**

**Part B** (For children in day-care centers, day-care homes, preschool, kindergarten and grades 1 through 12 who are incomplete for immunizations in Part A) **Indicate final expiration date:** (DOB Code 2)

I certify that the above named child has received the immunizations indicated on above and, has, continues and is intended to complete the required immunization. Additional circumstances are not medically indicated at this time.

**Permanent Medical Exemption**

**Part C-Permanent**

**Part C** (For medically contraindicated immunizations, but such variance and state will clinical reporting or evidence for exemption.) (DOB Code 3)

I certify the physical condition of this child is such that immunizations as indicated in Part C above are medically contraindicated.

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Physician or Child Nurse: \_\_\_\_\_      Physician or Authorized Signatory: \_\_\_\_\_  
 \_\_\_\_\_      Issued By: \_\_\_\_\_  
 \_\_\_\_\_      Date: \_\_\_\_\_

DH Form 150-015 (04/08)      1000-00000-000