Vaccine Administration Record

Patient Name Ahmed Busba

Birth Date 3/2/11

Record # 103-84

Clinic Name/Address
PEDIATRICS & ADOLESCENT MEDICINE
DR. S[illegible]LEY ROSENTHAL
DR. MONICA ROSENTHAL SAMS
11410 N. 56TH STREET
TAMPA, FLORIDA 33617
813-988-6141

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement was provided to me. By signing below, I agree that

- I have read or had explained to me the information about this disease and the vaccine.
- I had an opportunity to ask questions, and those questions were answered satisfactorily.
- I believe that I understand the benefits and risks of the vaccine.
- I ask that the vaccine be given to me or to the person named above (for whom I am authorized to make this request).

Every time I initial the "Parent/Guardian/Patient Initials" box, I agree that all of these actions have occurred for the vaccine listed in that row.

Parent/Guardian/Patient Signature _____ Date _____ Parent/Guardian/Patient Signature _____ Date _____

VACCINE	VACCINE ADMINISTERED			FUNDING SOURCE (F,S,P)†	VACCINE		VACCINE INFORMATION STATEMENTS		Parent/Guardian/Patient Initials	Vaccine Administrator Initials
	Date m/d/y	Patient Age	Site on Patient*		Name/ Manufacturer	Lot Number	Date Published	Date Provided		
Hep B 1	3/3/11				Tampa Gen. Nebraska					
Hep B 2	5/4/11	2 mo								
Hep B 3	9/6/11	6 mo								
Rota 1	5/4/11				Tampa Gen. Nebraska					
Rota 2	7/5/11	4 mo								
Rota 3	9/6/11	6 mo								
DT/DTaP 1	5/4/11									
DT/DTaP 2	7/5/11	4 mo								
DT/DTaP 3	9/6/11	6 mo			"			1		
DT/DTaP 4	6/14/12	15 mo								
DT/DTaP 5										
Hib 1	5/4/11									
Hib 2	7/5/11	4 mo			"			"		
Hib 3	9/6/11	6 mo								
Hib 4	3/6/12	1 yr.								
PCV 1	5/4/11									
PCV 2	7/5/11	4 mo			Tampa Gen. Nebraska					
PCV 3	9/6/11	6 mo								
PCV 4	3/6/12	1 yr								
IPV 1/OPV 1‡	5/4/11									
IPV 2/OPV 2‡	7/5/11	4 mo			"		"			
IPV 3/OPV 3‡	9/6/11	6 mo								
IPV 4/OPV 4‡										
MMR 1	3/20/12	1 yr								
Varicella 1	3/20/12	1 yr			"		"			
MMR 2										
Varicella 2										
Hep A 1	3/20/12				Tampa Gen. Nebraska					
Hep A 2	9/20/12	1 yr								
MCV4										
Tdap										
HPV 1										
HPV 2										
HPV 3										

(Circle one.) due 4yo

(Circle one.) due 4yo

due 4yo

due 4yo

11yo

11yo

11yo

11yo

11yo

*Site Legend: RA = Right Arm, LA = Left Arm, RT = Right Thigh, LT = Left Thigh, O = Oral, N = Nasal.

† F = Federal, S = State, P = Private.

‡ OPV is no longer recommended for routine immunizations.

Notes

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/YYYY)
Busba	Ahmed		3/2/11
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 DH Form 150-615, *Immunization Guidelines - Florida Schools, Childcare Facilities and Family Daycare Homes* (July 2011) 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	5/4/11	7/5/11	9/6/11	6/14/12	
DT Kda	B	5/4/11	7/5/11	9/6/11		
Tdap	P					
Td	Q					
Polio	D	5/4/11	7/5/11	9/6/11		
Hib	E	5/4/11	7/5/11	9/6/11	3/6/12	
MMR (Combined)	F	3/20/12				
(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	3/3/11	5/4/11	9/6/11		
Varicella	K	3/20/12				
Varicella Disease	L					
		Year				
PneumoConjugate	N	5/4/11	7/5/11	9/6/11	3/6/12	
MeningoConjugate	R					

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

Hep A 3/20/12
9/20/12

FU - 12/18/13

Part A-Complete

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

☐ DOE Code 8: Check box 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:** 3/2/15

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: PEDIATRICS & ADOLESCENT MEDICINE
DR. STANLEY ROSENTHAL
DR. MONICA ROSENTHAL SAMS
11410 N. 5TH STREET
TAMPA, FLORIDA 33617
813-988-5141

Physician or Authorized Signature: [signature]

Issued by: _____

Date: 12/19/13

DH 680 7/11 Stock Number: 5740-000-0680-6

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/YYYY)
Busba	Ahmed		3/2/11

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 DH Form 150-615, *Immunization Guidelines - Florida Schools, Childcare Facilities and Family Daycare Homes* (July 2011) 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	5/4/11	7/5/11	9/6/11	6/14/12	
DT Plota	B	5/4/11	7/5/11	9/6/11		
Tdap	P					
Td	Q					
Polio	D	5/4/11	7/5/11	9/6/11		
Hib	E	5/4/11	7/5/11	9/6/11	3/6/12	
MMR (Combined)	F	3/20/12				
(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	3/3/11	5/4/11	9/6/11		
Varicella	K	3/20/12				
Varicella Disease	L					
		Year				
PneumoConjugate	N	5/4/11	7/5/11	9/6/11	3/6/12	
MeningoConjugate	R					

Hep A 3/20/12
9/20/12.

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 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:** 11-1-14

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: PEDIATRICS & ADOLESCENT MEDICINE
DR. STANLEY ROSENTHAL
DR. MONICA ROSENTHAL SAMS
11410 N. 50TH STREET
TAMPA, FLORIDA 33617
813-988-5141

Physician or Authorized Signature: _____

Issued by: _____

Date: 1-28-14

DH 680 7/11 Stock Number: 5740-000-0680-6

FLORIDA DEPARTMENT OF HEALTH

Name of Child (Last, First, Middle)	Birth Date
Busba, Ahmed	3/2/11

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: 12 (Month) 18 (Day) 13 (Year)

(Exam must be within one year of enrollment)

Screening Results:
Height: 39 11 Weight: 33# BMI%: _____ B/P: _____ Hct/Hgb: 11.0 Lead: _____ Urinalysis: WNL.

Vision - Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☐	Failed ☐	Referred ☐

Gross dental (teeth and gums)	☑ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☑ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☑ Abnormal	Nasal sc, cough	Refer/Tx: _____
Chest/Lungs/Heart	☑ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☑ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☑ Normal	☐ 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)
☒	12/18/13	PEDIATRICS & ADOLESCENT MEDICINE DR. STANLEY ROSENTHAL DR. MONICA ROSENTHAL SAMS 11410 N. 56TH STREET TAMPA, FLORIDA 33617 813-988-5141
Name (Please print or stamp) DR. S. ROSENTHAL		

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.

Recommended Childhood and Adolescent Immunization Schedule* UNITED STATES • 2008

Calendario de vacunas recomendadas para niños y adolescentes

Vaccine/ *vacuna* ▼ Age/ *edad* ▶	Birth/ al nacer	1 month/ *mes*	2 months/ *meses*	4 months/ *meses*	6 months/ *meses*	12 months/ *meses*	15 months/ *meses*	18 months/ *meses*	19-23 months/ *meses*	2-3 years/ *años*	4-6 years/ *años*	7-10 years/ *años*	11-12 years/ *años*	13-18 years/ *años*
Hepatitis B*	HepB	HepB		*	HepB							HepB Series		
Rotavirus*			Rota	Rota	Rota									
Diphtheria, Tetanus, Pertussis*			DTaP	DTaP	DTaP	*	DTaP				DTaP	*	Tdap	Tdap
*Haemophilus influenzae type b**			Hib	Hib	*Hib**	Hib								
Pneumococcal*			PCV	PCV	PCV	PCV				PPV				
Inactivated Poliovirus*			IPV	IPV	IPV						IPV	IPV Series		
Influenza*					Influenza *(Yearly/anualmente)*							Influenza *(Yearly/anualmente)*		
Measles, Mumps, Rubella*						MMR					MMR	MMR Series		
Varicella*						Varicella					Varicella	Varicella Series		
Hepatitis A*						HepA (2 Doses)				HepA Series				
Meningococcal*										MCV4			MCV4	MCV4
Human Papillomavirus*												*	HPV (3 Doses)	HPV Series

DH150-916, 04/08 Stock Number 5731-916-0150-9 Take-One Schedules