



ROTARY YOUTH EXCHANGE FLORIDA, INC.

Sharing the World with the Sunshine State

WWW.RYEFLOIDA.ORG

Certificate of Immunization

Name of Student:	Date of Birth (day-month-year):
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This will certify that the above named student has been successfully immunized against the following diseases on the dates shown (*Please indicate day-month-year for all immunizations*):

	1	2	3	4	5
Diphtheria ¹					
Pertussis (whooping cough)					
Tetanus (Td)					XXXXX
Polio (oral)					XXXXX
Hepatitis "B"				XXXXX	XXXXX
Rubella (3 day measles) MMR or separate			XXXXX	XXXXX	XXXXX
Rubeola (regular measles) MMR or separate			XXXXX	XXXXX	XXXXX
Mumps MMR or separate			XXXXX	XXXXX	XXXXX
Tuberculosis ² (TB skin test)		XXXXX	XXXXX	XXXXX	XXXXX
Varicella ³			XXXXX	XXXXX	XXXXX

¹ Five doses required. If the 4th primary dose is administered on or after the 4th birthday a 5th dose is not required.

² Please attach explanation for any positive TB screen. For example, prior TB vaccine or TB exposure treated.

³ Varicella vaccine is not required if student has documentation of history of varicella disease (chicken pox).

Signature of Medical Doctor	Print Name of Medical Doctor
Street Address	City, State/Province, Country
Telephone Number	E-mail Address