Instructions for Submitting Immunization Record Transfers

1. Complete and submit the following information to the Florida Department of Health in Escambia County (DOH-Escambia) ***at least three weeks prior to school orientation/registration:***

    - Copies of child's immunization records with name and date of birth on each page
    - Completed **Immunization Record Transfers Form**
    - Copy of valid driver's license or passport of parent/guardian completing form
    - Copy of guardianship paperwork

2. **ALWAYS** keep original copies of your records. Never submit original documents.

3. Immunization documentation can be submitted in any of the following ways:

    - **Option 1, Fax:** 850-595-6586 (do not include a cover sheet)
      ATTN: Immunizations, 1295 West Fairfield Drive, Pensacola, FL 32501.

    - **Option 2, Dropoff in-Person** at our main location: **1295 West Fairfield Drive, Pensacola, FL 32501** at the **YELLOW WINDOW #9.**

4. Fees: Record transfer fee is **$20 per adult or child**. Copies of certified form DH680, Immunization History (DH686), or Clinic Record (DH687) are included in this fee.

5. All records will be processed in **5 BUSINESS DAYS**. Parents will be notified by a nurse if their child's vaccination history is not complete. Record submissions with **illegible and/or incomplete patient information will not be processed**.

6. Foreign language immunization records requiring translation take additional time to process. Please allow **7-10 BUSINESS DAYS** for these record transfers.

7. Completed immunization records can be picked up in-person at our main location at **1295 West Fairfield Drive, Pensacola, FL 32501**, at the **Medical Records, Window 9.** We cannot send email, mail or fax records to you.

Immunization Record Transfer Form

Today's Date: _____

Patient Identification:

Full Legal Name – AS IT APPEARS ON THE BIRTH CERTIFICATE (ATTACH COPY, IF AVAILABLE)

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ Grade in School this year (if applicable): _____
M M / D D / Y Y Y Y

Sex:
☐ Female ☐ Male

Language:
☐ English ☐ Other _____

Ethnicity:
☐ Non-Hispanic ☐ Hispanic/Latino

Race:
☐ African American/Black ☐ Caucasian/White ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Asian_____ ☐ Other _____

Patient Information:

Physical Address: _____

City: _____ State: _____ ZIP: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ - _____ - _____ Alternate Phone: _____ - _____-_____

Parent/Guardian Information – COPY OF INDENTIFICATION REQUIRED

FATHER

Last Name: _____ First Name: _____ Middle Name: _____

MOTHER

Last Name: _____ First Name: _____ Middle Name: _____

GUARDIAN – MUST SUBMIT COPY OF GUARDIANSHIP DOCUMENTS WITH FORM

Last Name: _____ First Name: _____ Middle Name: _____

For office use only:

☐ **FAXED TO MEDICAL RECORDS** ☐ **WINDOW 9 / CASHIER DROP-OFF**

Initials: _____ Receipt #:_____ Payment Stamp: