



# IMMUNIZATION POLICY ACKNOWLEDGMENT

## ARCHDIOCESE OF WASHINGTON – Catholic Schools

ALL PARENTS OF STUDENTS ATTENDING ARCHDIOCESAN CATHOLIC SCHOOLS IN MARYLAND MUST READ THIS FORM, SIGN BELOW, AND RETURN IT TO YOUR CHILD’S SCHOOL WITH THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE (ADAPTED FOR USE BY ARCHDIOCESAN SCHOOLS).

### To All Parents of Students in Archdiocesan Catholic Schools in Maryland

It is the policy of the Archdiocese of Washington that all students attending schools in the archdiocese must be fully immunized in accordance with the immunization requirements against contagious diseases published by the local department of health. If your child has a valid medical contraindication to being immunized, and such contraindication is documented by a physician, an exemption may be permitted for the length of time certified as necessary by the child’s physician.

Immunization in accordance with the Archdiocese of Washington’s policy is a condition for admission into all archdiocesan Catholic schools. To be admitted to attend classes, there must be two forms related to immunization on file at your child’s school by the first day of school, and they are:

1. THIS FORM, completed and signed; and
2. Maryland Department of Health and Mental Hygiene Immunization Certificate, (adapted for use by Archdiocese of Washington’s Catholic Schools in Maryland) signed by a medical provider and parents (Pages 2, 3, and 4).

### Acknowledgment

**To All Parents/Guardians: Please provide the following information and sign below to acknowledge that you understand and agree to this policy.**

Child’s Name: \_\_\_\_\_  
*Last First M.I. (Jr., III)*

School: \_\_\_\_\_ Sex:   Date of Birth: \_\_\_\_\_  
*Male Female mm/dd/yyyy*

Parent/Guardian Name: \_\_\_\_\_ Home Phone: ( ) - \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street Address Suite #*

\_\_\_\_\_  
*City State ZIP Code*

**I have read and understand the Archdiocese of Washington’s Immunization policy listed above:**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Please Sign mm/dd/yyyy*

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_  
LAST
FIRST
MI

SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 OR  
 GUARDIAN ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**RECORD OF IMMUNIZATIONS (See Notes On Other Side)**

Vaccines Type													
Dose #	DTP-DT <sub>a</sub> P-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name  
Office Address/ Phone Number

1. \_\_\_\_\_  
 Signature Title Date  
(Medical provider, local health department official, school official, or child care provider only)
2. \_\_\_\_\_  
 Signature Title Date
3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

Please check the appropriate box to describe the medical contraindication.

This is a:  Permanent condition OR  Temporary condition until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Medical Provider / LHD Official

\*Adapted for use by the Archdiocese of Washington's Catholic Schools in Maryland.

**PART I - HEALTH ASSESSMENT**

**To be completed by parent or guardian**

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex M  F   
 Last First Middle Mo / Day / Yr  
 Address: \_\_\_\_\_  
 Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Your Child's Routine Medical Care Provider  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone # \_\_\_\_\_

Your Child's Routine Dental Care Provider  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone \_\_\_\_\_

Last Time Child Seen for Physical Exam: \_\_\_\_\_  
 Dental Care: \_\_\_\_\_  
 Any Specialist: \_\_\_\_\_

**ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.**

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

No  Yes, name(s) of medication(s): \_\_\_\_\_

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

No  Yes, type of treatment: \_\_\_\_\_

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

No  Yes, what procedure(s): \_\_\_\_\_

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_ Date

OCC 1215 - Revised June 2016 - All previous editions are obsolete.

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**PART II - CHILD HEALTH ASSESSMENT**  
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: _____ <small style="display: flex; justify-content: space-between; font-size: 8px;">Last                      First                      Middle</small>	Birth Date: _____ <small style="display: flex; justify-content: space-between; font-size: 8px;">Month / Day / Year</small>	Sex M <input type="checkbox"/> F <input type="checkbox"/>
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1. Does the child named above have a diagnosed medical condition?  
 No     Yes, describe: \_\_\_\_\_

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.  
 No     Yes, describe: \_\_\_\_\_

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: (Please explain any abnormal findings.)  
\_\_\_\_\_  
\_\_\_\_\_

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: [http://earlychildhood.marylandpublicschools.org/system/files/11edep01/3/maryland\\_immunization\\_certification\\_form\\_dhmh\\_896\\_-\\_february\\_2014.pdf](http://earlychildhood.marylandpublicschools.org/system/files/11edep01/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf) This is found on Page 2 of the Archdiocese of Washington Form 3)

5. Is the child on medication?  
 No     Yes, indicate medication and diagnosis:  
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?  
 No     Yes, specify nature and duration of restriction: \_\_\_\_\_

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1                      Test#2	Test # 1                      Test #2

\_\_\_\_\_ has had a complete physical examination and any concerns have been noted above.  
(Child's Name)

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
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