



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. There are no exemptions permitted. Only if your child has a valid medical contraindication to being immunized against a contagious disease, and such contraindication is documented by a physician, will a temporary exemption be permitted.

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: Male Female Date of Birth: _____
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)

Dose #	Vaccines Type										Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr	
	DTP-DTaP-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 #						
1											1				
2											2				
3												Td	Tdap	Other	Other
4															
5															

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

- Signature _____ Title _____ Date _____
(Medical provider, local health department official, school official, or child care provider only)
- Signature _____ Title _____ Date _____
- Signature _____ Title _____ Date _____

Clinic / Office Name
Office Address/ Phone Number

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

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
 Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a permanent condition temporary condition until _____ / _____ / _____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
 Medical Provider / LHD Official

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Address: _____			_____		_____	
Number Street		Apt# City		State Zip		
Parent/Guardian Name(s)		Relationship		Phone Number(s)		
		W:		C:		H:
		W:		C:		H:
Where do you usually take your child for routine medical care? <u>Name:</u> _____						
Address: _____				Phone Number: _____		
When was the last time your child had a physical exam? Month: _____ Year: _____						
Where do you usually take your child for dental care? <u>Name:</u> _____						
Address: _____				Phone Number: _____		
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"/>				
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"/>				
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 Poisoning/Exposure	<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"/>				
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?						
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____						
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____						
Does your child require any special procedures? (catheterization, G-Tube, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> 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 _____	

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

Child's Name:	Birth Date:	Sex
Last First Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

RELIGIOUS OBJECTION:
 I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.
 Parent/Guardian Signature: _____ Date: _____

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: <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Additional Comments:

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

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age.

If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

Allegany ALL	Baltimore (cont) 21220 21221	Cecil 21913	Garrett ALL	Montgomery 20783 20787	Prince George's (cont) 20782 20783 20784 20785 20787 20788 20790 20791 20792 20799 20912 20913	St. Mary's 20606 20626 20628 20674 20687
Anne Arundel 20711 20714 20764 20779 21060 21061 21225 21226 21402	21222 21224 21227 21228 21229 21234 21236 21237 21239 21244 21250 21251 21282 21286	Charles 20640 20658 20662 Dorchester ALL Frederick 20842 21701 21703 21704 21716 21718 21719 21727 21757 21758 21762 21769 21776 21778 21780 21783 21787 21791 21798	Harford 21001 21010 21034 21040 21078 21082 21085 21130 21111 21160 21161 Howard 20763 Kent 21610 21620 21645 21650 21651 21661 21667	20812 20815 20816 20818 20838 20842 20868 20877 20901 20910 20912 20913 Prince George's 20703 20710 20712 20722 20731 20737 20738 20740 20741 20742 20743 20746 20748 20752 20770 20781	21607 21617 21620 21623 21628 21640 21644 21649 21651 21657 21668 21670 Somerset ALL	Talbot 21612 21654 21657 21665 21671 21673 21676 Washington ALL Wicomico ALL Worcester ALL
Baltimore 21027 21052 21071 21082 21085 21093 21111 21133 21155 21161 21204 21206 21207 21208 21209 21210 21212 21215 21219	Baltimore City ALL Calvert 20615 20714 Caroline ALL Carroll 21155 21757 21776 21787 21791					