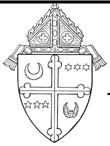

# IMMUNIZATION POLICY ACKNOWLEDGMENT

## 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: ☐ *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*



ARCHDIOCESE OF WASHINGTON
*Rev. September 1, 2010*

# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME______________________________________________
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE__________/_________/________

COUNTY _________________________ SCHOOL_____________________________ GRADE_______

PARENT OR GUARDIAN NAME _______________________________ PHONE NO. _______________________

ADDRESS _______________________________ CITY ___________________ ZIP________

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

Vaccines Type

| Dose # | 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 # | Hep A Mo/Day/Yr | MMR Mo/Day/Yr | Varicella Mo/Day/Yr | History of Varicella Disease |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 | | | | Mo/Yr |
| 2 | | | | | | | | | 2 | | | | |
| 3 | | | | | | | | | | Td ______ | Tdap ______ | Other ______ | Other ______ |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |

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

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.

Clinic / Office Name
Office Address/ Phone Number

**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

DHMH Form 896
Rev.3/09

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

## PART 1 HEALTH ASSESSMENT
**– To be completed by parent/guardian –**

_______________________________ ____/____/____ _______________________ ______
*Student Name (Last, First Middle)* *Birth Date* *School Name* *Grade*

_______________________________________________ ______-____-______
*Address (Street, City, State, Zip)* *Phone Number*

_______________________________ _______________________________
*Parent/Guardian (Male)* *Parent/Guardian (Female)*

_______________________________________________
*Physician/Nurse Practitioner Name and Address*

_______________________________________________
*Dentist Name and Address*

_______________________________________________
*Other source(s) from which the student receives health care. (If none, write "None.')*

### ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know? Please check (✓) "Yes," or "No" for each of the following:

| | Yes | No | Comments |
|---|---|---|---|
| Allergies (Drugs, Food, Insects) | | | describe reaction |
| Asthma | | | |
| Behavior or Emotional Problem | | | |
| Birth Defects | | | |
| Bladder Problem | | | |
| Bleeding Problems | | | |
| Bowel Problems | | | |
| Cerebral Palsy | | | |
| Concussion (Head Injury) | | | |
| Diabetes | | | |
| Ear Problem or Deafness | | | |
| Eye or Vision Problems | | | |
| Heart Problems | | | |
| Hospitalization (When, Where) | | | |
| Lead Poisoning | | | |
| Limits on Activity | | | |
| Medication | | | |
| Meningitis | | | |
| Prematurity | | | |
| Seizures | | | |
| Sickle Cell Disease | | | |
| Speech Problem | | | |
| Surgery | | | |

If you would like to discuss your child's health with school or school health personnel, please check title:
☐ Nurse assigned to school ☐ Teacher ☐ Counselor ☐ Principal

I give my permission for confidential and discreet use of Part 2, the health evaluation completed by the physician/nurse practitioner, to meet my child's health and educational needs in school. (Check (✓) one) ☐ Yes ☐ No

_______________________________ ____/____/____
*Signature, Parent/Guardian* *Date*

**IMPORTANT:** Schedule an appointment for a medical examination of your child; share the above information with the physician or nurse practitioner, have him/her complete Part 2 after the examination and then return the form to the school.

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

## PART 2 HEALTH EVALUATION
**– To be completed by physician/nurse practitioner –**

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school (e.g., seizures, asthma insect sting allergy, bleeding problem, diabetes, heart problem)? If "Yes", please describe.

   ☐ No ☐ Yes ______________________________

   ______________________________

2. Is this child on long-term technology assistance? ☐ No ☐ Yes ______________________________
3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a check (✓) in the appropriate box.

**CONCERN**

| **Health Area** | Yes | No | Not Evaluated | **Health Area** | Yes | No | Not Evaluated |
|---|---|---|---|---|---|---|---|
| Vision | ☐ | ☐ | ☐ | Adjustment | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | Nutrition | ☐ | ☐ | ☐ |
| Speech/Language | ☐ | ☐ | ☐ | Physical/Illness/Impairment | ☐ | ☐ | ☐ |
| Development | ☐ | ☐ | ☐ | Immunodeficiency | ☐ | ☐ | ☐ |
| Attention Deficit/Hyperactivity | ☐ | ☐ | ☐ | Lead Poisoning | ☐ | ☐ | ☐ |

Please explain all yes answers. Include recommendations for referral and treatment.

______________________________

______________________________

______________________________

______________________________

______________________________

4. Immunizations given on this visit: ☐ DPT/Td # _______; ☐ Polio # _______; ☐ MMR # _______; ☐ Other ___________
5. Tuberculin Test: Results ☐ Positive ☐ Negative _____ ____/____/____ _______ _____ ____/____ _____ ____/____/____

   Type Date (most recent) Height Weight BP Pulse Rate Date Taken

6. Is the student on long-term medication? If yes, please describe.

   ☐ No ☐ Yes ______________________________

   (MCPS Form *525-13: Authorization to Administer Prescribed Medication* must *be* completed for in-school administration

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

   ☐ No ☐ Yes ______________________________

   ______________________________

8. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below that are **NOT CROSSED OUT?**

   ☐ No ☐ Yes ☐ Not Applicable

| | | | |
|---|---|---|---|
| Baseball | Football | Pompons | Track/Field |
| Basketball | Golf | Soccer | Volleyball |
| Cheerleading | Gymnastics | Softball | Wrestling (minimum weight) |
| Cross Country | Indoor Track | Swimming/Diving | Other (specify) ___________ |
| Field Hockey | Lacrosse | Tennis | ___________ |

If you would like to discuss this student's health with school or school health personnel, check title below

☐ Nurse assigned to school ☐ Teacher ☐ Counselor ☐ Principal

Student Name (Type/print) ______________________ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

______________________ _____-_____-______ ______________________ ___/___/___

*Physician/Nurse Practitioner (Print)* *Phone Number* *Original Signature, Physician/Nurse Practitioner* *Date*

**IMPORTANT:** Maryland Immunization Certification is required by law. Please complete Form DHMH 896.

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