FORM 3

# 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. October 2016*

## 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 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

DHMH Form 896
Rev.02/14

***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 | Your Child's Routine Dental Care Provider | Last Time Child Seen for |
|---|---|---|
| Name: | Name: | Physical Exam: |
| Address: | Address: | Dental Care: |
| Phone # | Phone | 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.) | ☐ | ☐ | |
| Allergies (Seasonal) | ☐ | ☐ | |
| Asthma or Breathing | ☐ | ☐ | |
| Behavioral or Emotional | ☐ | ☐ | |
| Birth Defect(s) | ☐ | ☐ | |
| Bladder | ☐ | ☐ | |
| Bleeding | ☐ | ☐ | |
| Bowels | ☐ | ☐ | |
| Cerebral Palsy | ☐ | ☐ | |
| Coughing | ☐ | ☐ | |
| Communication | ☐ | ☐ | |
| Developmental Delay | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Ears or Deafness | ☐ | ☐ | |
| Eyes or Vision | ☐ | ☐ | |
| Feeding | ☐ | ☐ | |
| Head Injury | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Hospitalization (When, Where) | ☐ | ☐ | |
| Lead Poison/Exposure complete DHMH4620 | ☐ | ☐ | |
| Life Threatening Allergic Reactions | ☐ | ☐ | |
| Limits on Physical Activity | ☐ | ☐ | |
| Meningitis | ☐ | ☐ | |
| Mobility-Assistive Devices if any | ☐ | ☐ | |
| Prematurity | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |
| Sickle Cell Disease | ☐ | ☐ | |
| Speech/Language | ☐ | ☐ | |
| Surgery | ☐ | ☐ | |
| Other | ☐ | ☐ | |

**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.*

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

## PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

| Child's Name: Last / First / Middle | Birth Date: Month / Day / Year | Sex M ☐ F ☐ |
|---|---|---|

**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 | ☐ | ☐ | ☐ | Lead Exposure/Elevated Lead | ☐ | ☐ | ☐ |
| Behavior/Adjustment | ☐ | ☐ | ☐ | Mobility | ☐ | ☐ | ☐ |
| Bowel/Bladder | ☐ | ☐ | ☐ | Musculoskeletal/orthopedic | ☐ | ☐ | ☐ |
| Cardiac/murmur | ☐ | ☐ | ☐ | Neurological | ☐ | ☐ | ☐ |
| Dental | ☐ | ☐ | ☐ | Nutrition | ☐ | ☐ | ☐ |
| Development | ☐ | ☐ | ☐ | Physical Illness/Impairment | ☐ | ☐ | ☐ |
| Endocrine | ☐ | ☐ | ☐ | Psychosocial | ☐ | ☐ | ☐ |
| ENT | ☐ | ☐ | ☐ | Respiratory | ☐ | ☐ | ☐ |
| GI | ☐ | ☐ | ☐ | Skin | ☐ | ☐ | ☐ |
| GU | ☐ | ☐ | ☐ | Speech/Language | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | Vision | ☐ | ☐ | ☐ |
| Immunodeficiency | ☐ | ☐ | ☐ | Other: | ☐ | ☐ | |

**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/filedepot/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 | | |
| LeadTest Indicated:DHMH 4620 ☐ Yes ☐ 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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