



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 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 OR GUARDIAN NAME _____ PHONE NO. _____
 ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type														
Dose #	DTP-DT _a 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

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

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.

*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: _____ <small style="display:none">Last First Middle</small>	Birth Date: _____ <small style="display:none">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 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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MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B.

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 STREET ADDRESS (with Apartment Number) CITY STATE ZIP
 SEX: Male Female BIRTHDATE _____ / _____ / _____ PHONE _____
 PARENT OR GUARDIAN _____ / _____ / _____
 LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? YES NO
 Has this child ever lived in one of the areas listed on the back of this form? YES NO
 Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? YES NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments: _____

Person completing form: Health Care Provider/Designee OR School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

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HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

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

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

DHMH FORM 4620

REVISED 5/2016

REPLACES ALL PREVIOUS VERSIONS

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