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. 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 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 _____	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.

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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.

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