

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)

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	MWR Mo/Day/Yr	Vancella 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 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

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 DHMH 4620	<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: flex; justify-content: space-between; font-size: 8px;">Last First Middle</small>	Birth Date: _____ <small style="display: flex; justify-content: space-between; font-size: 8px;">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/mieepo03/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 %ile		
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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