

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

CHILD'S NAME _____												
				LAST			FIRST			MI		
SEX: MALE <input type="checkbox"/>		FEMALE <input type="checkbox"/>		BIRTHDATE _____/_____/_____								
COUNTY _____				SCHOOL _____				GRADE _____				
PARENT OR GUARDIAN NAME _____		PHONE NO. _____										
ADDRESS _____		CITY _____				ZIP _____						
RECORD OF IMMUNIZATION (See Notes)												
VACCINE TYPE							VACCINE TYPE					
DOSE #	DTaP/DTaP MO/DAY/YR	DT/dT MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep-B MO/DAY/YR	PCV7 MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR	
1							1					
2							2					
3							DOSE #	Varicella MO/DAY/YR	History of Varicella Disease Date - MO/YR	OTHER MO/DAY/YR	OTHER MO/DAY/YR	
4							1					
5							2					
To the best of my knowledge, the vaccines listed above were administered as indicated.								Office Stamp				
1. _____ Signature _____ Title _____ Date _____ <small>(Medical provider, local health department official, school official, or child care provider only)</small>								<div style="border: 1px solid black; width: 100%; height: 100%;"></div>				
2. _____ Signature _____ Title _____ Date _____												
3. _____ Signature _____ Title _____ Date _____												
Lines 2 and 3 are for certification of vaccines given after the initial signature.												

**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 OR RELIGIOUS 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 \_\_\_\_\_  
Physician or Health Officer

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **HOW TO USE THIS CERTIFICATE OF IMMUNIZATION**

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

### **Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## **CERTIFICATION INFORMATION**

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at [www.EDCP.org](http://www.EDCP.org) (Immunization). The requirement for hepatitis B and Varicella vaccine is a "progressive" regulation in which another successive grade(s) become covered by the regulation with each new school year.

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 07.04.01.29A, 07.04.02.44A and COMAR 07.04.05.34A. DHR COMAR and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guidelines chart are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).