

**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 IMMUNIZATION (See Notes)**

| VACCINE TYPE |                       |                    |                    |                  |                    |                   | VACCINE TYPE |                        |                      |                      |                    |
|--------------|-----------------------|--------------------|--------------------|------------------|--------------------|-------------------|--------------|------------------------|----------------------|----------------------|--------------------|
| DOSE #       | DTP-DTaP<br>MO/DAY/YR | DT-Td<br>MO/DAY/YR | Polio<br>MO/DAY/YR | Hib<br>MO/DAY/YR | Hep B<br>MO/DAY/YR | PCV7<br>MO/DAY/YR | DOSE #       | M-M-R<br>MO/DAY/YR     | MEASLES<br>MO/DAY/YR | RUBELLA<br>MO/DAY/YR | MUMPS<br>MO/DAY/YR |
| 1            |                       |                    |                    |                  |                    |                   | 1            |                        |                      |                      |                    |
| 2            |                       |                    |                    |                  |                    |                   | 2            |                        |                      |                      |                    |
| 3            |                       |                    |                    |                  |                    |                   | DOSE #       | Varicella<br>MO/DAY/YR | OTHER<br>MO/DAY/YR   | OTHER<br>MO/DAY/YR   | OTHER<br>MO/DAY/YR |
| 4            |                       |                    |                    |                  |                    |                   | 1            |                        |                      |                      |                    |
| 5            |                       |                    |                    |                  |                    |                   | 2            |                        |                      |                      |                    |

To the best of my knowledge, the vaccines listed above were administered as indicated.

Office Stamp

- \_\_\_\_\_  
Signature Title Date  
(Medical provider, local health department official, school official, or day care provider only.)
- \_\_\_\_\_  
Signature Title Date
- \_\_\_\_\_  
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 Official

**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 FORM**

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 or stamping the signature section. A different medical provider, local health department official, school official, or day 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 day care service. **Only a medical provider, local health department official, school official, or day care provider may sign ‘Record of Immunization’ section of this form.**

### **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.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/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 school principal or other person in charge of a school, public or private, may not knowingly admit a student to, or retain a student in a: 1) preschool program unless the student has furnished evidence of age-appropriate immunity against Haemophilus influenzae type b 2) preschool program or kindergarten through the second grade of school unless the student has furnished proof of age-appropriate immunity against pertussis; and 3) preschool program through the twelfth grade unless the student has furnished evidence of age-appropriate immunity against tetanus, diphtheria, poliomyelitis, measles (rubeola), mumps, rubella, hepatitis B and 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 becomes 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 “**Maryland DHMH Recommended Childhood Immunization Schedule**”. Please refer to Department of Human Resources COMAR 07.04.02.44 and COMAR 07.04.01.29 for childcare center and family day care home regulations. DHR COMAR regulations and the “**Maryland DHMH Recommended Childhood Immunization Schedule**” are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).