FORM 4

IMMUNIZATION POLICY ACKNOWLEDGMENT

ARCHDIOCESE OF WASHINGTON – Catholic Schools

ALL PARENTS OF STUDENTS ATTENDING ARCHDIOCESAN CATHOLIC SCHOOLS IN THE DISTRICT OF COLUMBIA MUST READ THIS FORM, SIGN BELOW, AND RETURN IT TO YOUR CHILD'S SCHOOL WITH THE DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE.

To All Parents of Students in Archdiocesan Catholic Schools in the District of Columbia

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. DC Universal Health Certificate, signed by a medical provider and parents (Pages 2 and 3).

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: **Holy Trinity 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*

*To parents of rising 6th, 7th, and 8th grade students: you MUST complete **Form 5 - HPV Vaccine Refusal Form** if your student is not receiving the HPV Vaccine

ARCHDIOCESE OF WASHINGTON
Rev. August 1, 2010

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.*

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐ M ☐ F	Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____
Parent or Guardian Name:	Telephone: ☐ Home ☐ Cell ☐ Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____	Primary Care Provider (PCP):		

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred							

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

***For use by the Archdiocese of Washington's Catholic Schools in the District of Columbia.**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:____/____/_____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:_____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

***For use by the Archdiocese of Washington's Catholic Schools in the District of Columbia.**

ARCHDIOCESE OF WASHINGTON
Rev. August 1, 2010