

CERTIFICATION INFORMATION

The following excerpt from the Code of Maryland Regulations (COMAR) 10.06.04 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 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, and rebella.

Immunization requirements for licensed child care centers (COMAR 07.04.02) and family day care homes (COMAR 07.04.01) are based on the Maryland DHMH recommended immunization schedule.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE (Recommended Immunization Schedule)

RECOMMENDED SCHEDULE

| <u>Age</u> | <u>Vaccine</u> |
|-------------------|--------------------------------|
| Birth | HBV |
| 2 mos. | DtaP, Polio, Hib, HBV |
| 4 mos. vaccine | DtaP, Polio, Hib |
| 6 mos. | DtaP, Hib, HBV |
| 12 mos. | MMR #1, Polio, Varicella |
| 15 mos. | Hib, DtaP |
| 4-6 yrs. | Polio, MMR #2, DtaP |
| 12 yrs. | MMR #2, (if not given earlier) |

ABBREVIATIONS

| |
|---|
| DtaP – Diphtheria and tetanus toxoids with acellular pertussis vaccine |
| Polio – Polio vaccine, oral or injectable |
| MMR – Measles, mumps, and rubella combined |
| Hib – <i>Haemophilus influenzae</i> type b vaccine (vaccine schedule may vary depending on the manufacturer) |
| HBV – Hepatitis B vaccine |
| Varicella – Chickenpox vaccine |

The medical provider that gave the vaccinations may record the dates directly on this form and certify them by signing or stamping the signature sections, OR, a different medical provider, a local health department official, a school official, or a 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.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed from Polio and DTP or DtaP but not for measles, mumps, or rubella. Reconstructed dates for Polio and DTP or DtaP must be reviewed and approved by the local health department. Blood test results are NOT acceptable evidence of DTP immunity. 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. ("Check marks" for vaccines given are not acceptable.)
2. History of diseases is NOT acceptable in lieu of any of the required immunizations, except chickenpox.
3. Children 12 months of age and older enrolled in licensed day care center(s), family day care homes, or pre-school educational programs must have one dose of measles, mumps and rubella vaccines, given on or after the first birthday.
4. Children enrolled in school grades K – 12 must have *two doses* of measles vaccine, with both doses given on or after the first birthday, and separated by at least 30 days (both doses of measles vaccine may be given as MMR).
5. Children enrolled in school grades K – 12 must have one dose of mumps and rubella vaccines, given on or after the first birthday.
6. All children under 60 months of age must be vaccinated for *Haemophilus influenzae* type b. Children in kindergarten and above do not need to show evidence of *Haemophilus influenzae* vaccination.
7. Hepatitis B vaccine and chickenpox vaccine will be required for pre-k enrollees beginning September, 2000.
8. Effective September 1, 1995, Hepatitis B vaccine is required for licensed child care facilities for new enrollees born on/after April 1, 1994.
9. Chickenpox vaccine will be required for licensed child care facilities, effective September, 1998, for children born on/after January 1, 1997.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MIDDLE
 SEX: MALE _____ FEMALE _____ BIRTHDATE _____
 COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____
 ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATION

| VACCINE TYPE | | | | | | VACCINE TYPE | | | | |
|--------------|---------------------|-----------------|-----------------|---------------|-----------------|--------------|-----------------------|---------------------|---------------------|---------------------|
| DOSE # | DTIP-DtaP MO/DAY/YR | DT-Td MO/DAY/YR | Polio MO/DAY/YR | Hib MO/DAY/YR | Hep B 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 | Other VAX MO/DAY/YR | Other VAX MO/DAY/YR | Other VAX MO/DAY/YR |
| 4 | | | | | | 1 | | | | |
| 5 | | | | | | 2 | | | | |

* Blood test verification of immunity and date may be entered in lieu of vaccination date
 ** Blood test verification of immunity or chickenpox disease date may be entered in lieu of Vaccination date.

PHYSICIAN, HEALTH/SCHOOL OFFICIAL, DAY CARE PROVIDER: TO THE BEST OF MY KNOWLEDGE, THE VACCINES LISTED ABOVE WERE ADMINISTERED AS INDICATED.

- _____
Signature Title Date
- _____
Signature-Initial Title Date
- _____
Signature-Initial Title Date
- _____
Signature-Initial Title Date

Lines 2-4 are for certification of vaccines given after initial signature

LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department.)

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 physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health. This is a permanent condition _____ temporary condition _____ until _____
 MO/DAY/YR

Check appropriate box, indicate vaccines(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 immunization being given to my child.

Signed _____ Date _____