

IMMUNIZATION POLICY ACKNOWLEDGMENT

THE ROMAN CATHOLIC ARCHDIOCESE OF WASHINGTON - CATHOLIC SCHOOLS

ALL PARENTS OF STUDENTS ATTENDING ARCHDIOCESAN CATHOLIC SCHOOLS IN THE DISTRICT OF COLUMBIA MUST <u>READ</u> THIS FORM, <u>SIGN</u> BELOW, AND <u>RETURN</u> 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 immunization requirements against contagious diseases published by the local department of health. If your child has a valid medical contraindication to being immunized, and such contraindication is documented by a physician, an exemption may be permitted for the length of time certified necessary by the child's physician.

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).

	Guardians: Please protand and agree to this	_	111011	nauon an	d sign below	to acknowledge		
Cilità 3 Ivanic.	Last	1	First		M.I.	(Jr., III)		
School:			ale	Female	Date of Birt	h:		
Parent/Guardian		Home Phone:						
Home Address:	Street Address				Suite #			
	City		S	tate	ZIP Code	2		
I have read and	understand the Archo	liocese of Washingt	ton's	Immuniz	ation policy li	isted above:		
Parent/Guardian Signature:						Date:		
					mm/dd/yyyy			
ū	sing 6 th Grade Students these forms but request F	•	l's pri	ncipal.				



GOVERNMENT OF THE DISTRICT OF COLUMBIA Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Parent/Guardian Name: Parent/Guardian Name: Parent/Guardian Phone: Emergency Contact Name: Emergency Contact Name: Emergency Contact Name: Emergency Contact Phone: Insurance Type: Medicaid Private None Insurance Name/ID #: No Insurance Name Name Name Name Name Name Name Nam	Part 1: Child Personal Information To be completed by parent/guardian.									
Home Address: Apt: City: State: ZiP:	Child Last Name:		Child First Name:			Date of Birth:				
Ethnicity: (check all that apply)	School or Child Care Facility Name:					Gender:	П ма	ale 🗀	Female	
Race: (check all that apply) Anerican Indian/ Alaska Native Anerican Indian/ Alaska Native Parent/Guardian Name: Emergency Contact Name: Emergency Contact Name: Emergency Contact Name: Has the child seen a dentist/dental provider within the last year? Igive 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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year. Parent/Guardian Phone: Has the child seen a dentist/dental provider within the last year? Igive 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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from chil liability for acts or omissions under DC Law 17-107. Examples and returned to my child's school every year. Parent/Guardian Phone: Emergency Contact Phone: Emergenc	Home Address:		Ap	t: Cit	y:			State:		ZIP:
Parent/Guardian Name: Parent/Guardian Phone: Parent/Guardian Phone: Emergency Contact Name: Emergency Contact Phone:	Ethnicity: (check all that apply) His	panic/Latino	Non-Hispa	anic/Non-Latin	0		Other		Prefer i	not to answer
Emergency Contact Name: Insurance Type: Medicaid Private None Insurance Name/ID #: Has the child seen a dentist/dental provider within the last year? Yes No Igive 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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year. Parent/Guardian Signature: Date: Paret 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Date of Health Exam: BP:	AIII		Asian					can	☐ White	Prefer not to answer
Insurance Type: Medicaid Private None Insurance Name/ID #: Has the child seen a dentist/dental provider within the last year? Yes No Igive 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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year. Parent/Guardian Signature: Date: Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Date of Health Exam: BP:	Parent/Guardian Name:				Pare	nt/Guardi	an Phone:			
Has the child seen a dentist/dental provider within the last year?	Emergency Contact Name:				Eme	rgency Cor	ntact Phone	2:		
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Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Date of Health Exam: BP:	appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.									
Date of Health Exam: BP:		, Exam, and Re	commer	ndations	To be c	ompleted	by license	ed heal	th care pro	ovider.
Screening: Left eye: 20/	Date of Health Exam: BP	/ -				Height:			вмі:	
Does the child have any of the following health concerns? (check all that apply and provide details below) Asthma	I DTT DVD : JII/ RIGH	nt eye: 20/_	=				Wears glas	ses \square	Referred	☐ Not tested
Asthma	Hearing Screening: (check all that apply		Pass	, D F	ail		Not tested		Uses Devi	ice 🔲 Referred
What is the child's risk level for TB? Skin Test Date: Quantiferon Test Date:	Asthma									
Chia Tast Baselton D	TB Assessment Positive TST should	be referred to Primar	ry Care Phys	sician for evalua	tion. For	questions	call T.B. Con	trol at 2	202-698-4040	D.
and/or Quantiferon test Low Quantiferon Results: Positive Positive, Treated	High complete skin to and/or Quantiferon test Low Skin Test Result Quantiferon Results:		Negative Positive, C				R Negative Positive, CXR Positive Positive, Treated			
Lead Exposure Risk Screening All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.										
ONLY FOR CHILDREN UNDER AGE 6 YEARS 1st Test Date: 1st Result: Normal Abnormal, Developmental Screening Date: 1st Serum/Finger Stick Lead Level:	ONLY FOR CHILDREN UNDER AGE 6 YEARS	: 1 st Resu	lt: N	ormal	bnormal,	-		<u>202-034</u>	1 st Ser Stick	rum/Finger Lead Level:
Every child must have 2 lead tests by age 2 HGB/HCT Test Date: 2nd Test Date: 2nd Result: Normal Normal, Developmental Screening Date: HGB/HCT Result: HGB/HCT Result:	2 lead tests by age 2	e: 2 nd Resu	ult: No	Develo	pmental	Screening D	ate:			. •

Child sat Stame:	Part 3: Immunization Information	1 To be com	pleted by licer	nsed health ca	re provider.					
Dightheria, Tetanus, Pertussis (DTP, DTAP)	Child Last Name:					Date of Birth:				
Diphtheria, Tetanus, Pertussis (LIP, Drain) Total Poositer Hoemophilus influenza Type b (Hib) Hepatitis (Reptil) Polio (RP, OPY) Mesales, Mumps, Rubella (MMR) Polio (RP, OPY) Mesales Mumps Polio (RP, OPY) Mesales Mumps Polio (Reptil) Polio (RP, OPY) Mesales Mumps Polio (Reptil) Medical Exemption (If applicable) Lectify that the above child has a valid medical contraindication(s) to being immunized at the time against: Diphtheria Tetanus Pertussis Hib HepB Polio Mesales Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV Reason for the medical exemption: Merinance of the medical exemption: Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV Reason for the medical exemption: Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV Reason for the medical exemption: Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV Part 4-! Licensed Health Practitioner's Certifications To be completed by increased health care provider. This child is cleared for competitive sports. N/A No Yes Yes, pending additional clearoner from: Intereby certify that I examined this child and the information recorded here was determined as a result of the examination. Provider Phone: Provider Phone: Provider Signature: Date:		In the boxes I	-							
Tidap Booster Haemophilus influenza Type b (Hib) 2		1			<u> </u>					
Hepatits (Hepa) 2 3 4	DT (<7 yrs.)/ Td (>7 yrs.)		2	3	4	3				
Hepatitis (Hupas) 7 3 4 Hepatitis (Hupas) 7 3 4 Messles, Mumps, Rubella (MMR) 7 Messles, Mumps, Rubella (MMR) 7 Messles, Mumps, Rubella (MMR) 7 Mumps 2 Rubella 2 Warfield by 2 Warfield by 2 Warfield by 2 Rubella 3 4 Hepatitis (Hupas) 3 Hepatitis (Hupas) 3 Hepatitis (Hupas) 6 Hepatitis (Hupas) 7 Mumps 2 Rubella 7 Perumococcal Conjugate 2 3 Hepatitis (Hupas) (Born on or after oly	· ·	1								
Deplice (PV, OPV) 1	Haemophilus influenza Type b (Hib)	1								
Mesales Mumps, Rubella (MMR) Mesales Mumps, Rubella (MMR) Preumococcal Conjugate Hepatitis Al HepAH (Born on or after OLYO/12/2005) Meningcocccal Vaccine Preumococcal Conjugate Hepatitis Al HepAH (Born on or after OLYO/12/2005) Meningcocccal Vaccine Human Papillomavirus (NPV) Preumococcal Vaccine Preumococcal HepA Meningococcal HPV Part 4: Licensed Health Practitioner's Certifications Tobe completed by licensed health care prouder. This child has beon appropriately avanined and health histopy reviewed and recorded in accordance with the terms specified on this Corn. Part 4: Licensed Health Practitioner's Certifications Tobe completed by licensed health care prouder. This child has leaboratory avanined and health histopy reviewed and recorded in accordance with the terms specified on this Corn. Provider Alme: Provider Signature: Date: Defice USE ONLY Universal Health Certificate received by School Official and Health Suite Personnel.	Hepatitis B (HepB)	1								
Measles Mumps Rubella 2		1		3	4					
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Numps Numbella	Measles	1								
Varicella Varicella Varicella Pneumococcal Conjugate Pneumococcal Conjugate Pneumococcal Conjugate Pneumococcal Conjugate Pneumococcal Conjugate Pneumococcal Conjugate Pneumococcal Vaccine Human Papillomavirus (HepA) Influenza (Recommended) Influenza (Recomme	Mumps	1								
Verified by:	Rubella	1								
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COVID-19 Is this medical contraindication permanent or temporary?	☐ Diphtheria ☐ Tetanus ☐ Per	tussis	Hib	□ н	ерВ 🔲	Polio	□ ме	asles		
Is this medical contraindication permanent or temporary?	Mumps Rubella Var	icella 🔲	Pneumococcal	□ н	ерА 🔲	Meningococca	al 🔲 HPV	J		
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Health Suite Personnel Name: Signature: Date:			-							