



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 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).

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: _____ Sex: _____ Date of Birth: _____
Male Female 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 Grade Students Only:

In addition to the District of Columbia Universal Health Certificate, you will be receiving information issued by the District of Columbia government concerning the new Human Papillomavirus (“HPV”) Vaccine. You have also received a letter from the Bishop, containing information about HPV in light of Catholic teaching.

As parents of a rising 6th grade student, if you have decided to opt out of the HPV vaccine for any reason, then you must completed the Human Papillomavirus Vaccine Refusal Form (Page 4) in addition to pages 1, 2, and 3 listed above.

Please check here if you chose to opt out of the HPV vaccine, and have returned the HPV Refusal Form:

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Part 1: Child Personal Information To be completed by parent/guardian.									
Child Last Name:		Child First Name:		Date of Birth:					
School or Child Care Facility Name:			Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Non-Binary				
Home Address:		Apt:	City:		State:	ZIP:			
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer									
Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer									
Parent First Name:		Parent Last Name:		Parent Phone:					
Emergency Contact Name:			Emergency Contact Phone:						
Insurance Type:		<input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None	Insurance Name/ID #:						
Has the child seen a dentist/dental provider within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No									
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. 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: _____ / _____	<input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight: _____	<input type="checkbox"/> LB <input type="checkbox"/> KG	Height: _____	<input type="checkbox"/> IN <input type="checkbox"/> CM	BMI: _____	BMI Percentile: _____
Vision Screening:		Left eye: 20/_____ Right eye: 20/_____	<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected	<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Referred	<input type="checkbox"/> Not tested			
Hearing Screening: (check all that apply) <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested <input type="checkbox"/> Uses Device <input type="checkbox"/> Referred									
Does the child have any of the following health concerns? (check all that apply and provide details below)									
<input type="checkbox"/> Asthma	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Sickle Cell							
<input type="checkbox"/> Autism	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. Details provided below.							
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. Details provided below.							
<input type="checkbox"/> Cancer	<input type="checkbox"/> Language/Speech	<input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. Details provided below.							
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other: _____							
<input type="checkbox"/> Development	<input type="checkbox"/> Scoliosis								
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures								
Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____									
TB Assessment Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.									
What is the child's risk level for TB?		Skin Test Date:			Quantiferon Test Date:				
<input type="checkbox"/> High → complete skin test and/or Quantiferon test		Skin Test Results:			<input type="checkbox"/> Negative	<input type="checkbox"/> Positive, CXR Negative	<input type="checkbox"/> Positive, CXR Positive	<input type="checkbox"/> Positive, Treated	
<input type="checkbox"/> Low		Quantiferon Results:			<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Positive, Treated		
Additional notes on TB test: _____									
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 <i>Every child must have 2 lead tests by age 2</i>	1 st Test Date:		1 st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:		1 st Serum/Finger Stick Lead Level:				
	2 nd Test Date:		2 nd Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:		2 nd Serum/Finger Stick Lead Level:				
HGB/HCT Test Date:				HGB/HCT Result:					

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:					Child First Name:			Date of Birth:		
Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)									
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	Child had Chicken Pox (month & year): Verified by: _____ (name & title)							
Pneumococcal Conjugate	1	2	3	4						
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2								
Meningococcal Vaccine	1	2								
Human Papillomavirus (HPV)	1	2	3							
Influenza (Recommended)	1	2	3	4	5	6	7			
Rotavirus (Recommended)	1	2	3							
Other	1	2	3	4	5	6	7			

The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)

I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

Diphtheria Tetanus Pertussis Hib HepB Polio Measles
 Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV

Is this medical contraindication permanent or temporary? Permanent Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

Diphtheria Tetanus Pertussis Hib HepB Polio Measles
 Mumps Rubella Varicella Pneumococcal HepA Meningococcal HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. No Yes

This child is cleared for **competitive sports**. N/A No Yes Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:		
	Provider Phone:		
	Provider Signature:	Date:	

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health**



Human Papillomavirus (HPV) Annual Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM

Section 1: Enter student information

Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
 - a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
 - b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
 - c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress this issue at any time and complete the required vaccinations.

Signature of Parent/Guardian or Student if >18 years

Date

Print Name of Parent/Guardian or Student if >18 years

Updated January 2015 (SY 2015-2016)

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-7130 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).



ARCHDIOCESE OF WASHINGTON

Archdiocesan Pastoral Center: 5001 Eastern Avenue, Hyattsville, MD 20782-3447
Mailing Address: Post Office Box 29260, Washington, DC 20017-0260
301-853-4500

Vicar General
and Moderator of the Curia

July 15, 2019

Re: Immunization information for parents of students entering sixth grade in archdiocesan schools in the District of Columbia

Dear Parents,

As you may be aware, the District of Columbia government issued new immunization requirements for students, which took effect in school year 2009-2010. To implement the new requirements, the District issued a standard immunization form, which is part of the "District of Columbia Universal Health Certificate."

As parents of a rising sixth-grade students in our Catholic schools, you should know that the District of Columbia Universal Health Certificate allows space for documentation of the Human Papillomavirus ("HPV") Vaccine, which may be administered by your child's physician. While the language of the law describes the change as the "HPV vaccination requirement", you should also know that parents are entitled to "opt out" of the HPV Vaccination for any reason.

The Archdiocese of Washington believes that the primary responsibility for the medical decision of whether or not to vaccinate a child against HPV rests with you the parents. Your discretion in making this decision with your child is critical and should be based on your own well-informed judgment.

In addition to the information provided by the District of Columbia regarding HPV, the Archdiocese would like the parents in its Catholic schools to have access to some consideration of the vaccine against HPV in light of Catholic teaching. As you know from our previous communications regarding the Archdiocesan Immunization Policy, the Church teaches that generally immunizing against disease is a morally responsible action that is important to sustaining the health of our communities.

¹ The law in the District of Columbia found at DCMR 22-146 states:

146.1 Beginning with the 2014/2015 school year, a student enrolling in grade six (6) for the first time shall receive the first dose of HPV vaccine at age eleven (11) and by age twelve (12) or complete an opt out form.

146.2 The second dose of HPV vaccine shall be administered not less than four (4) weeks after the first two (2) months after the first dose.

146.3 A third dose of HPV vaccine shall be administered not less than twelve (12) weeks after the second dose and by six (6) months after the first dose.

146.4 The parent or legal guardian of a student required to receive a vaccine under this section may opt out of the vaccination for any reason by signing a form provided by the Department that states that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate. A student eighteen (18) years of age or older may opt out on his or her own behalf by signing a form provided by the Department that states that the student has been informed of the HPV vaccination requirement and has elected not to participate.

Previously stated by the National Catholic Bioethics Center:

The National Catholic Bioethics Center notes that the Advisory Committee for Immunization Practices has recommended that young men and women be vaccinated against the human papilloma virus (HPV) as a protection against several types of cancers, which is caused by certain strains of this virus. HPV is spread through sexual contact, which includes, but is not limited to, sexual intercourse. Consequently, the most effective way to avoid contracting it is to abstain from sexual relations before marriage and to remain faithful within marriage.

The NCBC considers HPV vaccination to be a morally acceptable method of protecting against this disease, but asks that civil authorities leave this decision to parents and not make such immunization mandatory.

The prevalence of HPV in the reproductive age population makes exposure to the virus possible, even in a monogamous marriage, due to the possibility of a spouse's exposure prior to marriage. Furthermore, we live in a society where non-consensual sex remains a threat to young men and women who deserve to be protected from the effects of exposure to HPV.

However, as the *Catholic Medical Association Position Paper on HPV Immunization* provides, the HPV vaccine "can help to address one consequence of the spread of HPV, i.e., certain types of cancer. At the same time, to best promote the health and happiness of adolescents, physicians, parents and social institutions should redouble their efforts to promote chastity. Consistent messages about and support for this virtue will not only help to reduce disease, but will help individuals, couples, and marriages to flourish."

The Church teaches that parents are the primary caregivers of their children. Because each child is unique, the medical decision regarding the HPV vaccination for your child should be made through careful consideration of the medical, ethical and practical information available to your family.

This information is provided in the hope that it might be helpful as you and your child(ren) make this medical decision.

Faithfully in Christ,



Reverend Monsignor Charles V. Antonicelli
Vicar General Moderator of the Curia