



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 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 Roman Catholic 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 Roman Catholic 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 Roman Catholic 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:

Do NOT complete these forms but request Form 5 from the school’s principal.

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.

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: Male Female	
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"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input checked="" type="checkbox"/> Prefer not to answer				
Parent/Guardian Name:			Parent/Guardian 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 Exam:	BP: <input type="checkbox"/> NML <input type="checkbox"/> ABN	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 checked="" 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"/> Long term COVID-19 symptoms			
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care (details provided below)			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Language/Speech	<input type="checkbox"/> Long-Term Medications, over-the-counter drugs (OTC) or special care requirements. (details provided below)			
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Obesity	<input type="checkbox"/> Significant health history, condition, communicable illnesses, or restrictions (details provided below)			
<input type="checkbox"/> Developmental	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other:			
<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 (High 7 complete skin 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	

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 Every child must have 2 lead tests by age 2	1st Test Date:	1st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Developmental Screening Date:
	2nd Test Date:	2nd Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Developmental Screening Date:
HGB Test Date:		HGB Test 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							
Coronavirus (COVID) (Recommended)	1	2								
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: