Immunization Requirements

Saint John the Evangelist Catholic School follows Maryland Public School immunization requirements. Therefore, a Maryland Department of Health Immunization Certificate must be complete and up to date for your child to start school. If you have any questions or concerns about immunization requirements, please contact our school nurse (Kelly Williams, RN) at 410-592-9585 x104. This form can be submitted via fax (410-817-4548), email (kwilliams@stjohnschoollgv.org), hard copy to the front office ("attention Kelly Williams RN"), or by uploading to SchoolAdmin.

Pre-K 3 and Pre-K 4
(age: up to 4 years 11 months)

DTaP	Polio	Hib	MMR	Varicella	Hep B	PCV
4	3	1	1	1	3	1

Pre-K 4
(age: 5 years – 5 years 11 months)

DTap	Polio	MMR	Varicella	Hep B
4	3	2	1	3

Kindergarten – 6th Grade

DTap	Polio	MMR	Varicella	Hep B
3-4	3	2	2	3

7th and 8th Grades

DTaP	Polio	MMR	Varicella	Hep B	Tdap booster	MCV
3 or 4	3	2	2	3	1	1

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

Maryland
DEPARTMENT OF HEALTH

STUDENT/SELF NAME: _____
LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4								DOSE #4	DOSE #9
5	DOSE #5			DOSE #5									DOSE #5	DOSE #10

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD 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 vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____