MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE CHILD'S NAME LAST FIRST М SEX: MALE FEMALE BIRTHDATE / _ / COUNTY SCHOOL____ GRADE ____ PARENT NAME PHONE NO. OR GUARDIAN ADDRESS CITY ____ ZIP RECORD OF IMMUNIZATIONS (See Notes On Other Side) Vaccines Type Dose # DTP-DTaP-DT Polio Hep B PCV Rotavirus Mo/Day/Yr RECV HPV Hep A Varioella Mo/Day/Yr Varicella Morre 2 2 Tdap Mo/Day/Yr Mo/Day/Yr Mo/Day/Yr 4 5 To the best of my knowledge, the vaccines listed above were administered as indicated. Clinic / Office Name Office Address/ Phone Number Signature Title Date (Medical provider, local health department official, school official, or child care provider only) Signature Title Date Signature Title Date Lines 2 and 3 are for certification of vaccines given after the initial signature. 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 ____/ 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: __