# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

## RECORD OF IMMUNIZATION (See Notes)

| VACCINE TYPE | | | | | | | VACCINE TYPE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| DOSE # | DTP-DTaP MO/DAY/YR | DT-Td MO/DAY/YR | PolioMO/DAY/YR | Hib MO/DAY/YR | Hep B MO/DAY/YR | PCV7 MO/DAY/YR | DOSE # | M-M-R MO/DAY/YR | MEASLES MO/DAY/YR | RUBELLA MO/DAY/YR | MUMPS MO/DAY/YR |
| 1 | | | | | | | 1 | | | | |
| 2 | | | | | | | 2 | | | | |
| 3 | | | | | | | DOSE # | Varicella MO/DAY/YR | OTHER ___ MO/DAY/YR | OTHER ___ MO/DAY/YR | OTHER ___ MO/DAY/YR |
| 4 | | | | | | | 1 | | | | |
| 5 | | | | | | | 2 | | | | |

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 day 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.

Office Stamp

**LOST OR DESTROYED RECORDS:** (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Physician or Health 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 immunizations being given to my child.

Signed: _____ Date: _____