

**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	Polio MO/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	History of Varicella Disease Date - MO/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 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.

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 Officer

**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 \_\_\_\_\_