

[2D BARCODE]	Maryland State Department of Education/Office of Child Care Child Care Subsidy Program CHILD IMMUNIZATION FORM	Return To: CCS Central PO Box 17015 Baltimore, MD 21297
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Section 1 General Information	
Parent/Guardian Name:	
Child Name:	
Name of child's school:	
I attest that the medical records, including immunizations for my child were completed by my child's physician or health officer and are on file at the child's school. I further attest that my child has received all age appropriate immunizations.	
Signature (Parent/Guardian):	Date:

Complete the appropriate section below if the child is exempt from immunization on medical or religious grounds.

Section 2 Medical Contraindication	
The physical condition of the above child is such that immunization at this time would constitute a serious threat to his/her health. Check if this is a <input type="checkbox"/> Permanent condition <input type="checkbox"/> Temporary condition	
If this condition is temporary, indicate the date when immunization contraindication will end ____/____/____ (MM/DD/YYYY). Check appropriately and indicate relevant vaccines and reasons in the space provided below:	
Signature (Physician/Health Officer):	Date:

Section 3 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 immunization being given to my child.	
Signature (Parent/Guardian):	Date: