

ARCHDIOCESE OF WASHINGTON  
**IMMUNIZATION POLICY ACKNOWLEDGEMENT**

---

ALL PARENTS OF STUDENTS ATTENDING ARCHDIOCESAN CATHOLIC SCHOOLS IN THE DISTRICT OF COLUMBIA MUST READ THIS FORM, SIGN BELOW, AND RETURN IT TO YOUR CHILD'S SCHOOL WITH THE DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE.

To All Parents of Students in Archdiocesan Catholic Schools in the District of Columbia

It is the policy of the Archdiocese of Washington that all students attending schools in the archdiocese must be fully immunized in accordance with the immunization requirements against contagious diseases published by the local department of health. There are no exemptions permitted. Only if your child has a valid medical contraindication to being immunized against a contagious disease, and such contraindication is documented by a physician, will a temporary exemption be permitted.

Immunization in accordance with the Archdiocese of Washington's policy is a condition for admission into all archdiocesan Catholic schools. To be admitted to attend classes, there must be two forms related to immunization on file at your child's school by the first day of school, and they are:

1. DC Universal Health Certificate signed by a medical provider and parents (pages 1 and 2); and
2. THIS FORM, completed and signed;

**To All Parents:** Please provide the following information and sign below to acknowledge that you understand and agree to this policy:

Child's Name: \_\_\_\_\_  
Last First MI

Gender: Male:  Female:  Birth Date: \_\_\_\_\_ School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/ST: \_\_\_\_\_ Zip: \_\_\_\_\_

**I have read and understand the Archdiocese of Washington's Immunization policy listed above:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian

**To Parents of Rising 6<sup>th</sup> Grade Girls Only:**

In addition to the District of Columbia Universal Health Certificate, you will be receiving information issued by the District of Columbia government concerning the new Human Papillomavirus ("HPV") Vaccine. You have also received a letter from the Bishop, containing information about HPV in light of Catholic teaching.

As parents of a rising 6<sup>th</sup> grade girl, if you have decided to opt out of the HPV vaccine for any reason, then you must complete the Human Papillomavirus Vaccine Refusal Form provided by the school in addition to forms (1) and (2) listed above.

Please check here if you chose to opt out of the HPV vaccine, and have returned the HPV Refusal Form: .



# ARCHDIOCESE OF WASHINGTON

Archdiocesan Pastoral Center: 5001 Eastern Avenue, Hyattsville, MD 20782-3447  
Mailing Address: Post Office Box 29260, Washington, DC 20017-0260  
301-853-4500 TDD 301-853-5300

July 9, 2009

Vicar General  
and Moderator of the Curia  
Phone: 301-853-4520  
Fax: 301-853-5346

Re: Immunization information for parents of girls entering sixth grade  
in archdiocesan schools in the District of Columbia

Dear Parents,

The District of Columbia government has issued new immunization requirements for students, which will take effect in School Year 2009-2010. To implement the new requirements, the District has issued a new immunization form, which is part of the "District of Columbia Universal Health Certificate."

As parents of a rising sixth-grade female student in our Catholic schools, you should know that the District of Columbia Universal Health Certificate allows space for documentation of the new Human Papillomavirus ("HPV") Vaccine, which may be administered by your daughter's physician.<sup>1</sup> While the language of the law describes the change as the "HPV vaccination requirement" you should also know that parents are entitled to "opt out" of the HPV Vaccination for any reason.

The Archdiocese of Washington believes that the primary responsibility for the medical decision of whether or not to vaccinate a young woman against HPV rests with her parents. Your discretion in making this decision with your daughter is critical and should be based on your own well-informed judgment.

In addition to the information provided by the District of Columbia regarding HPV, the Archdiocese would like the parents in its Catholic schools to have access to some consideration of the vaccine against HPV in light of Catholic teaching. As you know from our previous communications regarding the Archdiocesan Immunization Policy, the Church teaches that generally immunizing against disease is a morally responsible action that is important to sustaining the health of our communities. Likewise, there is nothing intrinsically immoral associated with providing or receiving the HPV vaccine. In fact, the National Catholic Bioethics Center issued a statement on vaccination against HPV on July 11, 2006.

---

<sup>1</sup> The new law in the District of Columbia found at DCMR 22-146 states:

146.1 Beginning with the 2009/2010 school year, a female student enrolling in grade six (6) for the first time shall receive the first dose of HPV vaccine at age eleven (11) and by age twelve (12).

146.2 The second dose of HPV vaccine shall be administered not less than four (4) weeks after the first dose and by two (2) months after the first dose.

146.3 A third dose of HPV vaccine shall be administered not less than twelve (12) weeks after the second dose and by six (6) months after the first dose.

146.4 The parent or legal guardian of a student required to receive a vaccine under this section may opt out of the vaccination for any reason by signing a form provided by the Department that states that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

It stated the following, which is available at [http://www.ncbcenter.org/06-07-11-hpv\\_vaccine.asp](http://www.ncbcenter.org/06-07-11-hpv_vaccine.asp):

The National Catholic Bioethics Center notes that the Advisory Committee for Immunization Practices has recommended that young women be vaccinated against the human papilloma virus (HPV) as a protection against cervical cancer, which is caused by certain strains of this virus. HPV is spread through sexual contact which includes, but is not limited to, sexual intercourse. Consequently, the most effective way to avoid contracting it is to abstain from sexual relations before marriage and to remain faithful within marriage.

The NCBC considers HPV vaccination to be a morally acceptable method of protecting against this disease, but asks that civil authorities leave this decision to parents and not make such immunization mandatory.

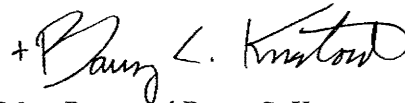
The prevalence of HPV in the reproductive age population makes exposure to the virus possible, even in a monogamous marriage, due to the possibility of a spouse's exposure prior to marriage. Furthermore, we live in a society where non-consensual sex remains a threat to young women who deserve to be protected from the effects of exposure to HPV.

However, as the *Catholic Medical Association Position Paper on HPV Immunization* provides, the HPV vaccine "can help to address one consequence of the spread of HPV, i.e., cervical cancer. At the same time, to best promote the health and happiness of adolescents, physicians, parents and social institutions should redouble their efforts to promote chastity. Consistent messages about and support for this virtue will not only help to reduce disease, but will help individuals, couples, and marriages to flourish."

The Church teaches that parents are the primary caregivers of their children. Because each child is unique, the medical decision regarding the HPV vaccination for your daughter should be made through careful consideration of the medical, ethical and practical information available to your family.

This information is provided in the hope that it might be helpful as you and your daughters make this medical decision.

Faithfully in Christ,

A handwritten signature in black ink that reads "+ Barry C. Knestout". The signature is written in a cursive style with a cross at the beginning.

Most Reverend Barry C. Knestout  
Moderator of the Curia

## **HUMAN PAPILLOMAVIRUS INFORMATION**

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no treatment for HPV, but the conditions it causes can be treated.

About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 10,000 women get cervical cancer and 3,700 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against 4 major types of HPV. These include 2 types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls 11-12 years. Doctors may give it to girls as young as 9 years. It is important for girls to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine. However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that girls or women with HPV get vaccinated.

The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger. It may be given with any other vaccines needed.

**HPV vaccine is given as a 3-dose series:**

- **1<sup>st</sup> Dose: Now**
- **2<sup>nd</sup> Dose: 2 months after Dose 1**
- **3<sup>rd</sup> Dose: 6 months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-9342 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

Department of Health



<b>Information about Human Papillomavirus and Vaccination and Vaccine Refusal Form for Students at District of Columbia Public, Charter, Private and Parochial Schools</b>			
<b>Instructions for completing HPV Vaccine Refusal Certificate</b>			
Section 1: Enter student information			
Section 2: Have parent/guardian or student (if ≥ 18 years of age) initial, sign and date after reading Vaccine Information Statement (s)			
Name of School			
<b>Section 1: Student Information</b>			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Recent legislation passed in 2007 by the District of Columbia City Council (DC Bill 17-30) requires all female students, enrolling in grade 6 for the first time at a school in the District of Columbia, to submit certification the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine because:
  - a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
  - b. The student's physician, his or her representative or the public health authorities has provided the school written certification that the vaccination is medically inadvisable; or
  - c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

**Human Papillomavirus (HPV) Vaccine Refusal**

I have received and reviewed the information provided on the human papillomavirus and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, I have decided to not to receive the HPV vaccine for the above named student. I know that I may re-address this issue at any time and complete the required vaccinations.

\_\_\_\_\_  
Signature of Parent/Guardian or Student if ≥18 years

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian or Student if ≥18 years



# DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

## Part 1: Child's Personal Information

Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 5 below.

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____
Parent or Guardian Name:	Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Home Address:	Ward:	
Emergency Contact Person:	Emergency Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	City/State (if other than D.C.)	Zip code:	
School or Child Care Facility:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other _____	Primary Care Provider (PCP):		

## Part 2: Child's Health History, Examination & Recommendations

Health Provider: Form must be fully completed.

DATE OF HEALTH EXAM:	WT <input type="checkbox"/> LBS <input type="checkbox"/> KG	HT <input type="checkbox"/> IN <input type="checkbox"/> CM	BP: _____ <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index (BMI) _____ %
HGB / HCT <i>(Required for Head Start)</i>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred	Hearing Screening Pass _____ Fail _____	<input type="checkbox"/> Referred
<b>HEALTH CONCERNS:</b>	<b>REFERRED or TREATED</b>	<b>HEALTH CONCERNS:</b>	<b>REFERRED or TREATED</b>	
Asthma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Language/Speech <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Seizure <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Development/Behavioral <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Other _____ <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Referred				

**A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.**  
 NONE  YES, please detail: \_\_\_\_\_

**B. Significant food/medication/environmental allergies that may require emergency medical care at school, child care, camp, or sports activity.**  
 NONE  YES, please detail: \_\_\_\_\_

**C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.**  
 NONE  YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

## Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS <input type="checkbox"/> HIGH → <input type="checkbox"/> LOW	Tuberculin Skin Test (TST) DATE:	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	If TST Positive <input type="checkbox"/> CXR NEGATIVE <input type="checkbox"/> CXR POSITIVE <input type="checkbox"/> TREATED	Health Provider: POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS <input type="checkbox"/> YES → <input type="checkbox"/> NO	LEAD TEST DATE:	RESULT:	Health Provider: ALL lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

## Part 4: Required Provider Certification and Signature

<input type="checkbox"/> YES <input type="checkbox"/> NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.		
<input type="checkbox"/> YES <input type="checkbox"/> NO This athlete is cleared for competitive sports.		
<input type="checkbox"/> YES <input type="checkbox"/> NO Age-appropriate health screening requirements performed within current year. If no, please explain: _____ _____		
Print Name	MD/NP Signature	Date
Address	Phone	Fax

## Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name	Signature	Date
------------	-----------	------

## DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Mo. /Day/ Yr.

Sex:  Male  Female School or Child Care Facility: \_\_\_\_\_

**Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.**

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
	1	2	3	4	5	6	7
Diphtheria, Tetanus, Pertussis (DTP, DTaP)							
DT (<7 yrs.) / Td (>7 yrs.)							
Tdap Booster							
Haemophilus influenza Type b (Hib)							
Hepatitis B (HepB)							
Polio (IPV, OPV)							
Measles, Mumps, Rubella (MMR)							
Measles							
Mumps							
Rubella							
Varicella							
Chicken Pox Disease History: Yes <input type="checkbox"/> When: Month _____ Year _____ Verified by: _____ (Health Care Provider) <small style="margin-left: 100px;">Name &amp; Title</small>							
Pneumococcal Conjugate							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
Meningococcal Vaccine							
Human Papillomavirus (HPV)							
Influenza (Recommended)							
Rotavirus (Recommended)							
Other							

Signature of Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: MEDICAL EXEMPTION For Health Care Provider Use Only**

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria:  Tetanus:  Pertussis:  Hib:  HepB:  Polio:  Measles:  Mumps:  Rubella:  Varicella:  Pneumococcal:

HepA:  Meningococcal:  HPV:

Reason: \_\_\_\_\_

This is a permanent condition  or temporary condition  until \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

Signature of Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_

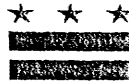
**Section 3: Alternative Proof of Immunity To be completed by Health Care Provider or Health Official**

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria:  Tetanus:  Pertussis:  Hib:  HepB:  Polio:  Measles:  Mumps:  Rubella:  Varicella:  Pneumococcal:

HepA:  Meningococcal:  HPV:

Signature of Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_



District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name		Child's First & Middle Name		Date of Birth	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	School or Child Care facility:	
Parent/Guardian Name		Telephone1: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Home Address:			Ward
Emergency Contact:		Telephone2: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		City/State (if other than D.C.):			Zip code:
Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____							
Primary Care Provider (Medical):			Dentist/Dental Provider:		<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other _____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)  
(Please use key to document all findings on line next to each tooth)

Date of Exam \_\_\_\_\_

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants	X - Missing teeth
● Restoration	Non-restorable/ Extraction
1D-One surface decay	UE- Unerupted Tooth
2D-Two surface decay	
3D-Three surface decay	
4D-More than three surface decay	

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y N	
2. Plaque and/or Calculus	Y N	
3. Abnormal Gingival Attachments	Y N	
4. Malocclusion	Y N	
5. Other (e.g. cleft lip/palate)		
Preventive services completed <input type="checkbox"/> Yes <input type="checkbox"/> No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment <input type="checkbox"/> is complete. <input type="checkbox"/> is incomplete. Referred to _____		
DDS/DMD Signature	Print Name	Date
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information. I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health	
PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	Date