

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE



STUDENT/SELF NAME: GALE MALIAH ANDREA
LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☒ OTHER ☐ BIRTH DATE: 08/20/2006

COUNTY: _____ SCHOOL: OXON HILL HIGH GRADE: 12

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	10/19/2006	10/19/2006	02/22/2007	08/20/2006	02/22/2007		08/31/2018			12/11/2007	04/06/2009		06/10/2021
2	02/22/2007	02/22/2007	04/19/2007	09/20/2006	12/11/2007					08/20/2010	08/20/2010		07/01/2021
3	04/19/2007	04/19/2007	12/11/2007	05/24/2007	05/24/2010				Td Mo/Day/Yr	Tdap Mo/Day/Yr 08/31/2018	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	04/06/2009	08/20/2010											
5	08/20/2010												

To the best of my knowledge, the vaccines listed above were administered as indicated.

- Signature _____ Title _____ Date _____
(Medical provider, local health department official, school official, or child care provider only)
- Signature _____ Title _____ Date _____
- Signature _____ Title _____ Date _____

Clinic / Office Name
Office Address/ Phone Number

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 _____ / _____ / _____
Date

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: _____

Immunization History

GALE, MALIYAH ANDREA

School: OXON HILL HIGH
 Grade: 12
 District ID: 100259269
 Home Room:

District:
 Birthdate: 08/20/2006
 Age: 17 yrs., 5 mos.

Region: Area 2
 Gender: Female

Vaccine

Vaccine	Dose Date	From State Registry	Vaccine	Dose Date	From State Registry
COVID-19 (Pfizer 0.3 mL)	06/10/2021	✓	COVID-19 (Pfizer 0.3 mL)	07/01/2021	✓
DTaP (Unknown)	10/19/2006		DTaP (Unknown)	02/22/2007	
DTaP (Unknown)	04/19/2007		DTaP (Unknown)	04/06/2009	
DTaP (Unknown)	08/20/2010		HepB (Unknown)	08/20/2006	
HepB (Unknown)	09/20/2006		HepB (Unknown)	05/24/2007	
Hib (Unknown)	02/22/2007		Hib (Unknown)	04/19/2007	
Hib (Unknown)	12/11/2007		Meningococcal (MCV4) (Unknown)	08/31/2018	
MMR (Unknown)	12/11/2007		MMR (Unknown)	08/20/2010	
Pneumococcal (Unknown)	02/22/2007		Pneumococcal (Unknown)	12/11/2007	
Pneumococcal (Unknown)	05/24/2010		Polio (Unknown)	10/19/2006	
Polio (Unknown)	02/22/2007		Polio (Unknown)	04/19/2007	
Polio (Unknown)	08/20/2010		Tdap (Unknown)	08/31/2018	
Varicella (Unknown)	04/06/2009		Varicella (Unknown)	08/20/2010	

Status

Series	Titer	Titer Results (Is Immune)	Titer Date	Titer Comment	Titer Result	Immune	Immune Date
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Immunization History