Medical Information

מכינת נר ישראל
Israel Henry Beren High School
400 Mt. Wilson Lane Baltimore, MD 21208
phone 410-484-7200 fax 410-484-3060 email mechina@nirc.edu

APPLICANT

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Parent's Email: _____

Father's (or guardian's) Cell: _____ Mother's (or guardian's) Cell: _____

Person to be contacted in an emergency if parent cannot be reached: _____

Relationship: _____ Phone Number: _____

Name of Physician: _____ _____ Phone: _____

Address: _____

IT IS IMPORTANT THAT WE HAVE YOUR ACCURATE INSURANCE INFORMATION!

Please affix a photocopy of the front and back of your son's insurance card.

Please tape front side of card here	Please tape reverse side of card here

MEDICAL INFORMATION

Name of policy holder: _____ Date of Birth of policy holder: ____ ____ ____

Will your insurance cover medical care in Maryland? _____

Please list any medications that you are taking on a regular basis: _____

Please list any allergies that you have: _____

Please list any surgeries, serious illnesses or hospitalizations you have had: _____

_____

Please list any medications to which you are allergic: _____

Are you presently consulting a psychologist, psychiatrist, and/or social worker? ☐ Yes ☐ No

If yes: Name _____ Phone number: _____

PARENTAL

Parental Permit For students under 18

I give permission for such diagnostic, therapeutic and operative procedures as may be deemed urgent and necessary by the resident physician or health-care professional, to be performed for my son _____
Student Name

Signature _____ Date: ____/____/____ Relationship: _____

MARYLAND DEPARTMENT OF HEALTH 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 IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

Clinic / Office Name
Office Address/ Phone Number

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.

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: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

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IMPORTANT HEALTH REQUIREMENT

To: All Yeshiva and Mechina Students and Parents/Guardians
From: Julian Jakobovits, M.D., Ner Israel Medical Director
Re: Maryland Meningitis Immunization Requirement for Students Residing On-Campus

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Maryland law requires that every individual enrolled at an institution of higher education such as Ner Israel and who resides in on-campus housing be vaccinated for meningococcal disease. This includes Kollel, Yeshiva and Mechina students who reside on-campus (dormitories or Yeshiva Lane housing). A student may be exempt from this vaccination if he meets the following condition: the student (or parent/legal guardian if student is less than 18 years of age), after having been advised of the risks of the disease and the availability and effectiveness of the vaccine, signs a written waiver stating that he has received and reviewed information and has chosen not to be vaccinated against the disease. Please have this form completed and returned to the Ner Israel office.

Directions for Completing this Form:

1. Please print all information requested in all sections of this form as required below.
2. All students residing on-campus must complete both sides of this form (sections A and then either B, or C).

For Section B: Please have your physician complete Section B. We will also accept a copy of your personal medical records from your physician or an international certificate of vaccination, if the record reflects the information required in Section B. Copies should be attached to this form.

For Section C: If you are seeking an exemption from this law, please read the information below and sign the waiver (Section C) on side 2.

Section A: TO BE COMPLETED BY ALL STUDENTS (Please Print)
(If student will be living off campus, please check here ___ and complete Section A)

Name (Last)_____(First)_____(Middle Initial)_____

Student Status (check ✓ one): □ U.S. Citizen, □ Permanent Resident, □ International

Social Security Number:_____ Date of Birth:_____

Permanent Address:_____
(Include City/State or Country)

Phone No.:_____ □ Kollel, □ Yeshiva, ☑ Mechina

(turn over and complete reverse side)

Section B: TO BE COMPLETED ONLY FOR STUDENTS WHO HAVE RECEIVED THE MENINGOCOCCAL VACCINE

(Signed physician documentation must be included below or attached)

	Dates	Vaccine Type
Meningococcal Vaccine	_____	_____
	_____	_____
	_____	_____

**Depending on the type of vaccine, it may be effective approximately five years (Menomune) to life-long immunity (Menectra). Students who received the Menomune vaccine should check with their doctor if they require an update to their immunization, and be in compliance with the law.

PHYSICIAN SIGNATURE:_____DATE:_____
PHYSICIAN NAME (Print):_____PHONE NO._____

Section C: TO BE COMPLETED BY STUDENTS REQUESTING AN EXEMPTION.

I understand that under Maryland law, students enrolled in a Maryland institution of higher education and who reside in on-campus student housing are required to be vaccinated against meningococcal disease. With this waiver, I seek exemption from this requirement. I have read the health information provided where the risks of the disease are detailed. In addition, I acknowledge the detrimental health effects of the disease. Lastly, I have read and understand the availability and effectiveness of the vaccine which may be available from my physician or other health provider and voluntarily choose to waive receipt of meningococcal vaccine.

I voluntarily agree to release, discharge, indemnify and hold harmless the Ner Israel Rabbinical College, its officers, employees and agents from all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the law.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

_____	_____	_____
Name of Student (Print)	Signature of Student	Date

If the Student is under age 18, a parent/guardian must sign this waiver below.

_____	_____	_____
Name of Parent/Guardian (Print)	Signature of Parent/Guardian	Date

Issued: 6/00 (rev. 12/09)
File: ajl-Vaccination form (rev 12/09).ni