



### 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: <sup>(≥3 yrs)</sup> <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index <sup>(≥2 yrs)</sup> (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)							
Name & Title _____							
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 \_\_\_\_\_