



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 Name/ID Number_____		Primary Care Provider (PCP):	

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

Health Practitioner: 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: _____ <small>(≥3yrs)</small> <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index <small>(≥2yrs)</small> (BMI) _____ % _____
HGB / HCT <small>(Required for children under age 6)</small>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred <input type="checkbox"/> Attempted	Hearing Screening Pass _____ Fail _____	<input type="checkbox"/> Device <input type="checkbox"/> Referred <input type="checkbox"/> Attempted
HEALTH CONCERNS:	REFERRED or TREATED	HEALTH CONCERNS:		REFERRED or TREATED
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	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx
Seizures <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	<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	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx
ANNUAL DENTIST VISIT: Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Referred <input type="checkbox"/> Fluoride Varnish Date: _____				

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
 NONE YES, please provide details:

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

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements. NONE YES, please provide details.
(For any medications or treatment required during school hours, a Licensed Health Practitioner's Medication Plan or 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 Practitioner: POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	LEAD TEST DATE:	RESULT:	Health Practitioner: ALL lead levels must be reported to DC Childhood Lead and Healthy Housing Program: Fax: 202-535-2607		

Part 4: Required Licensed Health Practitioner's Certification and Signature

<input type="checkbox"/> YES <input type="checkbox"/> NO This child has been appropriately examined & health history reviewed and recorded in accordance with the items specified on this form. At time of the 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/APRN/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information/civil liability waiver)

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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Print Name

Signature

Date

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Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's signature and date.								
IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN							
	1	2	3	4	5			
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 Practitioner)								
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 Licensed Health Practitioner	Print Name or Stamp			Date				
Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner 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 Licensed Health Practitioner	Print Name or Stamp			Date				
Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner 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 Licensed Health Practitioner	Print Name or Stamp			Date				