DISTRIBUTION OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form replaces all forms dated before February 24, 2009. This District of Columbia Universal Health Certificate (DCUHC) will be used for entry into Child Care Facilities, Head Start and DC public, private and parochial schools. 

Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DCUHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) guidelines for child and adolescent preventive health care; from birth to 21 years of age. This form is a confidential document, consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for health providers, and the Family Educational Rights and Privacy Act of 1974 (FERPA) for educational institutions.

General Instructions: Please use a black ball point pen when completing this form.

Part 1: Child’s Personal Information:

Parent or Guardian: Please complete all of your child’s personal information including the child’s last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which the address is located, and the name and phone number of an emergency contact in case you cannot be reached.

Provide the name of the school or child care facility. Check the box that describes your child’s type of health insurance coverage. If the child’s type of insurance coverage is not listed, check “other” and write the type of coverage in the space provided. Write the name of your child’s primary care provider (doctor). If your child does not have a primary care provider, write “none” in the space provided. This form will not be complete without the parent or guardian’s signature in Part 5.

Part 2: Child’s Health History, Examination & Recommendations: (To be completed by the health care provider). Please mark all relevant boxes.

- **Date of Health Exam:** All children must have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate the date of the examination.
- **WT:** Child’s weight in either pounds (LBS) or kilograms (KG); **HT:** Child’s height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is 2 years of age or older, the BMI has to be calculated and recorded inclusive of percentile.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is required for Head Start children. Also, anemia screening is recommended for menstruating adolescents based on AAP guidelines. Please record blood level and indicate which test was performed by circling HGB, HCT or both.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other disorders that may require special health care needs. For any of the health screens where there are “HEALTH CONCERNS,” the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. If there are NO/NONE “HEALTH CONCERNS”, then check the “NO” or “None” box in each health screening area.
- **SPECIAL NOTE:** “Annual Dentist Visit” – for children three years of age and older, the health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If “No”, the should be referred to a dentist.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child’s ability to perform in a school-related activity or program or mark “NONE”.
- **B:** Please note any significant allergies that may require emergency medical care at a school-related activity or program or mark “NONE”.
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark “NONE”.
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Physician’s Medication Authorization Order and attached it to the health certificate.

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

- **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform risk assessment for TB as defined by the AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2006 RED BOOK, 27th Ed., page 682. Current DC regulations require one TST (Tuberculin Skin Test) for all children entering child care or school; whichever comes first. TST is also required for all children who are assessed as HIGH RISK OF EXPOSURE. Please note the test and mark the test outcome (positive or negative). If the TST is positive, then mark the chest X-Ray outcome (CXR) and whether the child was treated. All positive TSTs must be reported to the DC T.B. Control Program on 202-698-4040.
- **LEAD EXPOSURE RISKS:** DC law requires that all children are tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6. Please document both the “Date” and “Result” of most recent lead test. Please indicate if “Pending.” “Pending” results will be valid for two months from date of testing and will not exclude a child from school-related activity or program. ALL lead tests must be reported electronically by labs to the DC Childhood Lead Poisoning Prevention Program. For detailed instructions, call 202-654-6036/6037. Providers may fax results to: 202-481-3770.

Part 4: Required Provider (physician or practitioner) Certification and Signature:

The provider will respond by marking “Yes” or “No” to the following statements:

The child was appropriately examined with a review of the health history;

The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation 2nd Ed. (1997); and

The child has received age-appropriate screenings (in accordance with AAP and EPSDT guidelines) within the current year. If “No” is marked, explain the reason in the space provided.

All information will be kept confidential.

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

The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the health provider to share the health information on this form with the child’s school, child care facility, camp or appropriate DC Government agency.

Forms are available online at [www.doh.dc.gov](http://www.doh.dc.gov)
### Part 6: IMMUNIZATION INFORMATION

**General Instructions:** Please use black ball point pen when completing form.

**Child/Student Personal Information:** Print clearly child/student last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

**Section 1: Immunization Information** – Enter clearly date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider’s signature and date. As required by D.C. Law 3-20, “Immunization of School Students of 1979” and DCMR Title 22, Chapter 1 (revised May 2, 2008), the following immunizations are required.

**Instructions:** Find the age of the child/student in the column labeled “Child’s Current Age”. Read across the row for each required vaccine. The number in the box is the number of doses required for that vaccine based on the CURRENT age or grade level of the child. The age range in the column does not mean that the child has until the highest age in that range to meet compliance. Any child whose age falls within that range must have received the required number of doses based on his/her CURRENT age in order to be in compliance.

#### Vaccine types and dosage numbers required for children enrolled in Child Care Programs**1,2**

<table>
<thead>
<tr>
<th>Child’s Current Age</th>
<th>DTP/DTaP/D</th>
<th>Polio</th>
<th>Hib</th>
<th>MMR</th>
<th>Varicella</th>
<th>Hepatitis B</th>
<th>Hepatitis A</th>
<th>Pneumococcal Conjugate <strong>1</strong></th>
<th>Meningococcal</th>
<th>Human Papillomavirus (HPV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 months</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2 – 3 months</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>4 – 5 months</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<td>0</td>
<td>2</td>
<td>0</td>
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<tr>
<td>6 – 11 months</td>
<td>3</td>
<td>3</td>
<td>2/3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12 – 14 months</td>
<td>3</td>
<td>3</td>
<td>3/4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15 – 23 months</td>
<td>4</td>
<td>3</td>
<td>3/4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24 – 47 months</td>
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<td>3</td>
<td>3/4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>48 – 59 months</td>
<td>5</td>
<td>4</td>
<td>3/4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Vaccine types and dosage numbers required for children enrolled in Public, Charter, Parochial and Private Schools**1**

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>DTP/DTaP/D</th>
<th>Polio</th>
<th>Hib</th>
<th>MMR</th>
<th>Varicella</th>
<th>Hepatitis B</th>
<th>Hepatitis A</th>
<th>Pneumococcal Conjugate</th>
<th>Meningococcal</th>
<th>Human Papillomavirus (HPV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade K – 5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
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<td>0</td>
</tr>
<tr>
<td>Grades 6 – 12</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

1Spacing: Doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day, must be separated by a minimum of 28 days.

2Exceptions: Medical exemptions from immunizations may be granted for valid reasons with proper documentation from health care provider (Section 2). Blood titers may be obtained in lieu of immunizations (Section 3). A copy of the lab report must be submitted to school/child care facility. Documentation for religious exemptions must be submitted by parent/guardian to the school/child care facility.

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**Section 2: Medical Exemption** – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name or stamp and date this section.

**Section 3: Alternative Proof of Immunity** – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name or stamp and date this section.