



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: _____ <small>(≥3 yrs)</small> <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index (BMI) % _____ <small>(≥2 yrs)</small>
HGB / HCT <small>(Required for Head Start)</small>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred	Hearing Screening Pass _____ Fail _____ <input type="checkbox"/> Referred	
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	
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

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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		
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) <small style="margin-left: 150px;">Name & Title</small>							
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 _____