



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: _____ (^{>3 yrs}) <input type="checkbox"/> NML <input type="checkbox"/> ABNL | Body Mass Index (BMI) _____ (^{>2 yrs}) % _____ |
| HGB / HCT (Required for Head Start) | 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 | <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 | <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: (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 | | |
| 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 _____