



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 <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
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

YES 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.

YES NO This athlete is cleared for competitive sports.

YES 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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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 _____