

# DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at <https://dchealthlink.com>. You may contact the Health Suite Personnel through the main office at your child's school.

## Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:		Child First Name:		Date of Birth:							
School or Child Care Facility Name:			Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary					
Home Address:		Apt:	City:	State:	ZIP:						
Ethnicity: (check all that apply)											
<input type="checkbox"/>	Hispanic/Latino	<input type="checkbox"/>	Non-Hispanic/Non-Latino	<input type="checkbox"/>	Other	<input type="checkbox"/>	Prefer not to answer				
Race: (check all that apply)											
<input type="checkbox"/>	American Indian/ Alaska Native	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Native Hawaiian/ Pacific Islander	<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	White	<input type="checkbox"/>	Prefer not to answer
Parent/Guardian Name:				Parent/Guardian Phone:							
Emergency Contact Name:				Emergency Contact Phone:							
Insurance Type:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private	<input type="checkbox"/> None	Insurance Name/ID #:							
Has the child seen a dentist/dental provider within the last year?											
				<input type="checkbox"/> Yes	<input type="checkbox"/> No						
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. I understand that this form should be completed and returned to my child's school every year.											
Parent/Guardian Signature:				Date:							

## Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	BP:	<input type="checkbox"/> NML	Weight:	<input type="checkbox"/> LB	Height:	<input type="checkbox"/> IN	BMI:	BMI Percentile:
	____/____	<input type="checkbox"/> ABNL		<input type="checkbox"/> KG		<input type="checkbox"/> CM		
Vision Screening:		<input type="checkbox"/> Corrected		<input type="checkbox"/> Wears glasses		<input type="checkbox"/> Referred		<input type="checkbox"/> Not tested
Left eye: 20/____		Right eye: 20/____		Uncorrected				
Hearing Screening: (check all that apply)			<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	<input type="checkbox"/> Uses Device	<input type="checkbox"/> Referred	

Does the child have any of the following health concerns? (check all that apply and provide details below)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Sickle cell
<input type="checkbox"/> Autism	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Long term COVID-19 symptoms
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. Details provided below.
<input type="checkbox"/> Cancer	<input type="checkbox"/> Language/Speech	<input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. Details provided below.
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Obesity	<input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. Details provided below.
<input type="checkbox"/> Developmental	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note.

## TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?	Skin Test Date:	Quantiferon Test Date:			
<input type="checkbox"/> High → complete skin test and/or Quantiferon test	Skin Test Results:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive, CXR Negative	<input type="checkbox"/> Positive, CXR Positive	<input type="checkbox"/> Positive, Treated
<input type="checkbox"/> Low	Quantiferon Results:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Positive, Treated	

Additional notes on TB test:

## Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS Every child must have 2 lead tests by age 2	1 <sup>st</sup> Test Date:	1 <sup>st</sup> Result:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal,	Developmental Screening Date:	1 <sup>st</sup> Serum/Finger Stick Lead Level:
	2 <sup>nd</sup> Test Date:	2 <sup>nd</sup> Result:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal,	Developmental Screening Date:	2 <sup>nd</sup> Serum/Finger Stick Lead Level:

HGB/HCT Test Date:	HGB/HCT Result:
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**Part 3: Immunization Information** | To be completed by licensed health care provider.

Child Last Name:		Child First Name:				Date of Birth:		
<b>Immunizations</b>		<b>In the boxes below, provide the dates of immunization (MM/DD/YY)</b>						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5			
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5			
Tdap Booster	1							
Haemophilus influenza Type b (Hib)	1	2	3	4				
Hepatitis B (HepB)	1	2	3	4				
Polio (IPV, OPV)	1	2	3	4				
Measles, Mumps, Rubella (MMR)	1	2						
Measles	1	2						
Mumps	1	2						
Rubella	1	2						
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)					
Pneumococcal Conjugate	1	2	3	4				
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2						
Meningococcal Vaccine	1	2						
Human Papillomavirus (HPV)	1	2	3					
Influenza (Recommended)	1	2	3	4	5	6	7	
Rotavirus (Recommended)	1	2	3					
Coronavirus (COVID) (Recommended)	1	2						
Other	1	2	3	4	5	6	7	

The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** \_\_\_\_\_

**Medical Exemption (if applicable)**

I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

- Diphtheria     Tetanus     Pertussis     Hib     HepB     Polio     Measles  
 Mumps     Rubella     Varicella     Pneumococcal     HepA     Meningococcal     HPV

Is this medical contraindication permanent or temporary?     Permanent     Temporary until: \_\_\_\_\_ (date)

**Alternative Proof of Immunity (if applicable)**

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

- Diphtheria     Tetanus     Pertussis     Hib     HepB     Polio     Measles  
 Mumps     Rubella     Varicella     Pneumococcal     HepA     Meningococcal     HPV

**Part 4: Licensed Health Practitioner's Certifications** | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one.     No     Yes

This child is cleared for **competitive sports**.     N/A     No     Yes     Yes, pending additional clearance from: \_\_\_\_\_

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp

Provider Name:

Provider Phone:

Provider Signature:

Date:

**OFFICE USE ONLY** | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:

Signature:

Date:

Health Suite Personnel Name:

Signature:

Date: