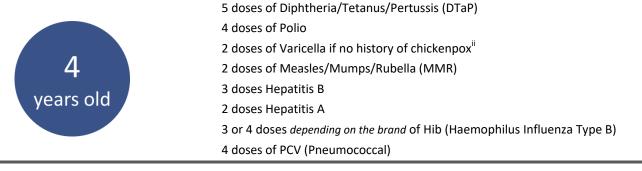
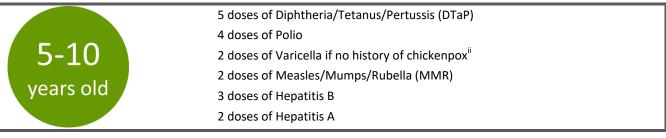
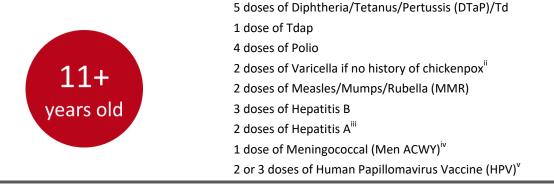
All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

On the first day of school my student is: By the start of SY19-20, my student should have received: 4 doses of Diphtheria/Tetanus/Pertussis (DTaP) 3 doses of Polio 1 dose of Varicella if no history of chickenpox ii 1 dose of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A 3 or 4 doses depending on the brand of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)







¹ The number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's health suite personnel or health care provider for details.

^{II} All Varicella/chickenpox histories <u>MUST</u> be verified by a health care provider and documented with month and year of disease.

iii If born on or after 01/01/05.

iv Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

^v Two doses if student receives first dose between ages 9 -14 (doses 6-12 months apart); 3 doses if student starts series on or after age 15.



Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Part 1: Child Perso	onal Informatio	n To be completed	d by paren	nt/guardian.				
Child Last Name:		Ch	ild First Na	me:			Date of Birth	:
School or Child Care Fac	ility Name:				Gender:	☐ Male	☐ Female	Non-Binary
Home Address:			Apt:	City:		Sta	ite:	ZIP:
Ethnicity: (check all that app	oly) 🔲 Hispanic/La	tino 🔲 Non-H	Hispanic/No	n-Latino		Other	☐ Prefer	not to answer
Race: (check all that apply)	American II Alaska Nati			Native Hawai Pacific Islande		Black/African American	☐ White	Prefer not to answer
Parent First Name:		Parent Last N	ame:			Parent P	hone:	
Emergency Contact Nan	ne:			Emo	ergency Co	ntact Phone:		
Insurance Type:	Medicaid \Box	Private 🔲 None	Insurance	Name/ID #:				
Has the child seen a der	ntist/dental provider	within the last year?	-	Yes	□ 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: Date:						ents shall be immune		
Part 2: Child's Hea	Ith History, Exa	m, and Recomm	endatio	ns To be c	ompleted	by licensed h	ealth care p	ovider.
Date of Health Exam:	BP: /	NML WE	eight:	□ LB □ KG	Height:	□ IN		BMI Percentile:
Vision Screening:	20/ Right	eye: 20/	Correcte Uncorre			Wears glasses	Referred	Not tested
Hearing Screening: (chec	k all that apply)		Pass	☐ Fail		Not tested	Uses De	vice \square Referred
Does the child have any of the following health concerns? (check all that apply and provide details below) Asthma								
TB Assessment Posi	tive TST should be ref	erred to Primary Care Pl	hysician for	evaluation. For	questions	call T.B. Control	at 202-698-40	40.
What is the child's risk	level for TB? Skin	est Date:			Quan	tiferon Test D	ate:	
☐ High → complete and/or Quantifero		Test Results:	Negative	Positive,	CXR Negativ	ve Positiv	ve, CXR Positive	Positive, Treated
Low		tiferon Results:	Negative	Positive		Positiv	ve, Treated	
Additional notes on TB test:								
Lead Exposure Risk S	creening All lead I	evels must be reported	to DC Childh	nood Lead Pois	oning Preve	ntion. Call 202-	654-6002 or Fa	ıx: 202-535-2607
ONLY FOR CHILDREN UNDER AGE 6 YEARS	1 st Test Date:	1 st Result:	Normal	Abnormal Developmental	,		1 st Se	erum/Finger Lead Level:
Every child must have 2 lead tests by age 2	2 nd Test Date:	2 nd Result:	Normal	Abnormal Developmental	•	Date:		erum/Finger Lead Level:
HGB/HCT Test Date:			HGB	/HCT Result:			'	

Part 3: Immunization Information To	be completed by licens	ed health care provider.				
Immunizations Pro	vide in the boxes below th	e dates of Immunization (N	/IM/DD/YY)			
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	2 3	4	5			
DT (<7 yrs.)/ Td (>7 yrs.)	2 3	4	5			
Tdap Booster						
Haemophilus influenza Type b (Hib)	2 3	4				
Hepatitis B (HepB)	2 3	4				
Polio (IPV, OPV)	2 3	4				
Measles, Mumps, Rubella (MMR)	2					
Measles ¹	2					
Mumps	2					
Rubella	2					
Varicella		hild had Chicken Pox (mont	h & year):			
Pneumococcal Conjugate 1	2 3	4				
Hepatitis A (HepA) (Born on or after 01/01/2005)	2					
Meningococcal Vaccine	2					
Human Papillomavirus (HPV)	2 3					
Influenza (Recommended)	2 3		5 6 7			
Rotavirus (Recommended)	2 3					
The child is behind on immunizations and there	o is a plan in place to get hi	m/har back on schodula N	ovt appointment is:			
The child is behind on initializations and their	e is a plan in place to get in	my her back on schedule. No	ext appointment is.			
Medical Exemption (if applicable)						
I certify that the above child has a valid medical conti	raindication(s) to being imn	nunized at the time against	:			
☐ Diphtheria ☐ Tetanus ☐ Pertus.	sis 🔲 Hib	□ НерВ [Polio Measles			
☐ Mumps ☐ Rubella ☐ Varice	la Pneumococc	al 🗖 HepA 🕻	Meningococcal HPV			
Alternative Proof of Immunity (if applicable) I certify that the above child has laboratory evidence of	of immunity to the followin	g and I've attached a copy	of the titer results.			
Diphtheria Tetanus Pertus.	sis 🔲 Hib	☐ HepB [Polio Measles			
☐ Mumps ☐ Rubella ☐ Varicel		·	☐ Meningococcal ☐ HPV			
varices	iia — Filediilococc	ат 🗀 пера	ivieningococcai			
Part 4: Licensed Health Practitioner's Co	ertifications To be o	ompleted by licensed he	alth care provider.			
This child has been appropriately examined and healt	th history reviewed and rec	orded in accordance with th	ne No Yes			
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. This child is cleared for competitive sports. Additional clearance(s) needed from: N/A No Yes, pending additional						
			clearance			
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 Phone:				
	Provider Signature:	Provider Signature:				
	Date:					
Access health insurance programs at https://dchealthlink.com . You may contact the Health Suite Personnel through the main office at your child's school.						
		I Suite Personner through the r				
School Official Name:	Signate		Date:			
Health Suite Personnel Name:	Signati		Date:			



Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

School or Child Care Facility Name	Part 1: Student Information (To be completed by pare	nt/guardian)	
Part 2: Student's Oral Health Status (To be completed by the dental provider) Yes No 1 Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots). Does the patient have at least one treated carious tooth? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment. Does the patient have at least one permanent molar tooth with a partially or fully retained sealant? Does the patient have untreated caries or other oral health problems requiring care before his/her coutine check-up? (Early care need) Does the patient have pain, abscess, or swelling? (Urgent care need) Does the patient have pain, abscess, or swelling? (Urgent care need) Total Number Of How many of primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns, or extracted due to caries? Total Number Of How many of permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries? Does the patient have Does the patient have? Does the patient have Does No.	First Name Last Name School or Child Care Facility Name Date of Birth (MMDDYYYY) Ho		
Q1 Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots). Q2 Does the patient have at least one treated carious tooth? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment. Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant? Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need) Q5 Does the patient have pain, abscess, or swelling? (Urgent care need) Q6 How many of primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns? Total Number Q7 How many of permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries? Total Number Q8 What type of dental insurance does the patient have? Medicaid Private Insurance Other None Dental Provider Name Dental Office Stamp	Grade care Pre-K3 Pre-K4 1 2 3 4 5	6 7 8 9	10 11 12 Ed.
Q1 Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots). Q2 Does the patient have at least one treated carious tooth? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment. Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant? Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need) Q5 Does the patient have pain, abscess, or swelling? (Urgent care need) Q6 How many of primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns? Total Number Q7 How many of permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries? Total Number Q8 What type of dental insurance does the patient have? Medicaid Private Insurance Other None Dental Office Stamp	Part 2: Student's Oral Health Status (To be completed l	by the dental provid	der)
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Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need) Q5 Does the patient have pain, abscess, or swelling? (Urgent care need) Q6 How many of primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns? Total Number Q7 How many of permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries? Total Number Total Number Dental Provider Name Dental Office Stamp		-	
Q6 How many of primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns? Q7 How many of permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries? Q8 What type of dental insurance does the patient have? Medicaid Private Insurance Other None Dental Provider Name Dental Office Stamp	Q4 Does the patient have untreated caries or other oral health problems req		
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untreated, treated with fillings/crowns, or extracted due to caries? Other None Dental Provider Name Dental Office Stamp			tal Number
Dental Provider Name Dental Office Stamp			tal Number
	Q8 What type of dental insurance does the patient have? Medicaid	Private Insurance	Other None
	Dental Provider Name	Dental (Office Stamp
•	Dental Provider Signature		
Dental Examination Date	Dental Examination Date		

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.





Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information	1 To be completed by stud	ent's parent/caretaker.			
Student First Name: Stu	ident Last Name:	Grade:			
School Facility Name:		Student DOB:			
Parent First Name:	Parent Last Name	:			
Parent Email:	·	Parent Phone:			
I hereby request and authorize Health Suite Personnel to administe providers to the student named in Part I. I understand that:	r prescribed medication/treatme	nt as directed by the licensed health care			
I am responsible for bringing the necessary medications/medical states.	• •				
• All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.					
Within one week of the expiration of the medication/medical support it will be destroyed.					
The School or Health Suite Personnel will not assume any responsi					
 If any changes occur in my student's health or treatment plan, I wi Official Code § 38-651.03. 					
 Treatment plans and medication plans must be updated annually a I hereby acknowledge that the District, and its schools, employees, 107 except for criminal acts, intentional wrongdoing, gross neglige 	, and agents shall be immune from	·			
Parent/Caretaker Signature:	nice, or williar misconduct.	Date:			
	4 - d b - 1 d b 14b				
Part 2a: Student's Medication Plan To be comple					
	d date for school administrat				
This medication is: U New; the first dose was given at ho					
Is this a standing order? Yes, epinephrine auto injector 0.1	• • • • • •	Yes, other:			
Yes, epinephrine auto injector 0.3	mg: refer to anaphylaxis plan	□ No			
Yes, albuterol sulfate 90 mcg/inh:	refer to asthma action plan				
Name and strength of medication:		Dose/route:			
Time and Frequency at School (e.g. 10am and 2pm every day; as ne	eded if standing order)				
If a reaction can be expected, please describe:					
Additional instructions or emergency procedures:					
Part 2b: Student's Medical Procedure Treatment	Plan To be completed by	licensed health care provider.			
Diagnosis:	This procedure is:				
Treatment:		3			
When should treatment be administered at school? (e.g. 10a)	m and 2pm every day)				
End date for school administration of this treatment:					
Additional instructions or emergency procedures:					
Has the student's Universal Health Certificate form been upo	lated to reflect new health co	ncerns?			
Licensed Health Care Provider Office Stamp	Provider Name:				
	Provider Phone:				
	Provider Signature:	Date:			
OFFICE USE ONLY Medication and/or treatment plan	received by Health Suite Pers	onnel.			
Name: Signat	ture:	Date:			