

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Please complete and return your student’s school health forms including the [Universal Health Certificate](#) and [Oral Health Assessment Form](#).  
**ALL STUDENTS SHOULD RECEIVE AN ANNUAL FLU VACCINE**

My student should receive these vaccine doses upon school enrollment*	
 <p><b>2-3</b> years old</p> <p><b>Preschool to Head Start</b></p>	<p><b>The following vaccines are typically received before the age of 2:</b></p> <ul style="list-style-type: none"> <li>4 doses of Diphtheria/Tetanus/Pertussis (DTaP)</li> <li>3 doses of Polio</li> <li>1 dose Varicella if no history of chickenpox</li> <li>1 dose of Measles/Mumps/Rubella (MMR)</li> <li>3 doses of Hepatitis B</li> <li>2 doses of Hepatitis A</li> <li>3 or 4 doses depending on the brand of Hib (Haemophilus Influenza Type B)</li> <li>4 doses of PCV (Pneumococcal)</li> </ul>
 <p><b>4-6</b> years old</p> <p><b>Kindergarten to 1<sup>st</sup> Grade</b></p>	<p><b>Additional doses needed <u>after</u> receiving the vaccines listed above:</b></p> <ul style="list-style-type: none"> <li>1 dose of Diphtheria/Tetanus/Pertussis (DTaP)</li> <li>1 dose of Polio</li> <li>1 dose of Varicella if no history of chickenpox</li> <li>1 dose of Measles/Mumps/Rubella (MMR)</li> </ul>
 <p><b>7-10</b> years old</p> <p><b>2<sup>nd</sup> Grade to 5<sup>th</sup> Grade</b></p>	<p><b>Consult your doctor and make sure your student received <u>all</u> the vaccines listed above!</b></p>
 <p><b>11+</b> years old</p> <p><b>6<sup>th</sup> Grade to High School</b></p>	<p><b>Additional vaccines needed <u>after</u> receiving <u>all</u> vaccine doses listed above:</b></p> <ul style="list-style-type: none"> <li>1 dose of Tdap</li> <li>2 doses of Meningococcal (Men ACWY)</li> <li>2 or 3 doses of Human Papillomavirus Vaccine (HPV)</li> </ul>

\*The spacing and number of doses required may vary. Please contact your child’s health care provider. For additional information, contact DC Health’s Immunization Program at (202) 576-7130.

# 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 <input type="checkbox"/> ABNL	Weight: _____ <input type="checkbox"/> LB <input type="checkbox"/> KG	Height: _____ <input type="checkbox"/> IN <input type="checkbox"/> CM	BMI: _____	BMI Percentile: _____
Vision Screening: Left eye: 20/____ Right eye: 20/____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected		<input type="checkbox"/> Wears glasses <input type="checkbox"/> Referred <input type="checkbox"/> Not tested			
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"/> Significant food/medication/environmental allergies that may require emergency medical care. <i>Details provided below.</i> |
| <input type="checkbox"/> Behavioral     | <input type="checkbox"/> Kidney failure    | <input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. <i>Details provided below.</i>            |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Language/Speech   | <input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. <i>Details provided below.</i>                |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Obesity           |  |
| <input type="checkbox"/> Developmental  | <input type="checkbox"/> Scoliosis         |  |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Other: _____  |

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? <input type="checkbox"/> High → complete skin test and/or Quantiferon test <input type="checkbox"/> Low	Skin Test Date:	Quantiferon Test Date:	
	Skin Test Results:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative	<input type="checkbox"/> Positive, CXR Positive <input type="checkbox"/> Positive, Treated
	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:	

**Part 3: Immunization Information** | To be completed by licensed health care provider.

<b>Child Last Name:</b>					<b>Child First Name:</b>			<b>Date of Birth:</b>		
<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							
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.

<b>Licensed Health Care Provider Office Stamp</b>	<b>Provider Name:</b>		
	<b>Provider Phone:</b>		
	<b>Provider Signature:</b>	<b>Date:</b>	

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

<b>School Official Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Health Suite Personnel Name:</b>	<b>Signature:</b>	<b>Date:</b>

**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.

**Part 1: Student Information (To be completed by parent/guardian)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

School or Child Care Facility Name \_\_\_\_\_

Date of Birth (MMDDYYYY)

--	--	--	--	--	--	--	--

Home Zip Code

--	--	--	--	--	--

School Grade	Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	<input type="checkbox"/>																

**Part 2: Student's Oral Health Status (To be completed by the dental provider)**

	Yes	No		
Q1 Does the patient have at least one tooth with <b>apparent cavitation</b> (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).	<input type="checkbox"/>	<input type="checkbox"/>		
Q2 Does the patient have at least one <b>treated carious tooth</b> ? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a <b>partially or fully retained sealant</b> ?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring <b>care before his/her routine check-up? (Early care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have <b>pain, abscess, or swelling? (Urgent care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q6 How many <b>primary teeth</b> in the patient's mouth are affected by caries that are either <b>untreated or treated with fillings/crowns</b> ?	Total Number			
	<input type="text"/>			
Q7 How many <b>permanent teeth</b> in the patient's mouth are affected by caries that are either <b>untreated, treated with fillings/crowns, or extracted due to caries</b> ?	Total Number			
	<input type="text"/>			
Q8 What type of dental insurance does the patient have?	Medicaid	Private Insurance	Other	None
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Provider Name _____	Dental Office Stamp
Dental Provider Signature _____	
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.