DC HEALTH Immunization Requirements for School Year 2019-2020

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:[i]
2-3 years old	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)
4 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses Hepatitis B 2 doses Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
5-10 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A
11+ years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP)/Td 1 dose of Tdap 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A[iii] 1 dose of Meningococcal (Men ACWY)[iv] 2 or 3 doses of Human Papillomavirus Vaccine (HPV)[v]

[i] 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 MUST 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.

DC HEALTH Universal Health Certificate

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 Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)* ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer		
Race: *(check all that apply)* ❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer		
Parent First Name:	**Parent Last Name:**	**Parent Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	
Has the child seen a dentist/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:** _____

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

Date of Health Exam:	**BP:** ____/____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

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

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Development
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney Failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **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?

❑ High → *complete skin test and/or Quantiferon test*

❑ Low

Skin Test Date: / **Quantiferon Test Date:**

Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated

Quantiferon Results: ❑ Negative ❑ Positive ❑ 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*	**1st Test Date:**	**1st Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date: / **HGB/HCT Result:**

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

Immunizations	Provide in the boxes below the dates of Immunization (MM/DD/YY)						
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):				
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				

❑ 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

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.** Additional clearance(s) needed from: _____ ❑ N/A ❑ No ❑ Yes ❑ 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 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.

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:**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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	Pre-K3	Pre-K4	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 **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 Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

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.

DC | HEALTH

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 | To be completed by student's parent/caretaker.

Student First Name:	**Student 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 administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- 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 supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	**End date for school administration of this medication:**

This medication is: ❑ New; the first dose was given at home on date and time: _____ ❑ Renewal ❑ Change

Is this a standing order?
- ❑ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
- ❑ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
- ❑ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
- ❑ Yes, other: _____
- ❑ No

Name and strength of medication:	**Dose/route:**

Time and Frequency at School *(e.g. 10am and 2pm every day; as needed 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:** ❑ New ❑ Renewal ❑ Change

Treatment:

When should treatment be administered at school? *(e.g. 10am 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 updated to reflect new health concerns? ❑ Yes ❑ No

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 Personnel.

Name:	**Signature:**	**Date:**