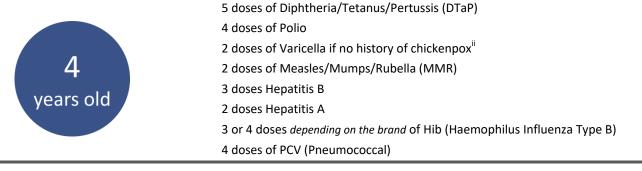
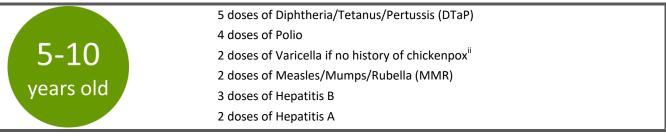
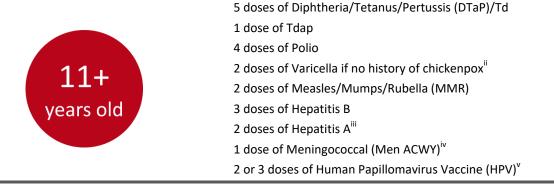
All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

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 Information To	be completed	by paren	t/guardian.				
Child Last Name: Child Firs				ne:			Date of Birth	n:
School or Child Care Fac	ility Name:				Gender:	☐ Male	☐ Female	☐ Non-Binary
Home Address:			Apt:	City:		Sta	ite:	ZIP:
Ethnicity: (check all that app	Hispanic/Latino	☐ Non-H	ispanic/No	n-Latino		Other	☐ Prefer	not to answer
Race: (check all that apply)	American Indian/ Alaska Native	Asian		Native Hawai Pacific Islande		Black/African American	☐ White	Prefer not to answer
Parent First Name:		Parent Last Na	ame:			Parent P	hone:	
Emergency Contact Nan	ne:			Em	ergency Co	ntact Phone:		
Insurance Type:	Medicaid 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:								
Part 2: Child's Hea	lth History, Exam, ar	nd Recomm	endatior	is To be c	ompleted	by licensed h	ealth care p	rovider.
Date of Health Exam:	BP: /	NML We	ight:	□ LB □ KG	Height:	□ IN		BMI Percentile:
Vision Screening:	20/ Right eye: 20	D/	Correcte Uncorrec			Wears glasses	Referred	d Not tested
Hearing Screening: (chec	k all that apply)	☐ P	ass	☐ Fail		Not tested	Uses De	vice 🔲 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 referred to	Primary Care Ph	ysician for e	valuation. For	questions c	all T.B. Control	at 202-698-40	40.
What is the child's risk					Quan	tiferon Test D	ate:	
☐ High → complete and/or Quantifero		sults:	Negative	Positive,	CXR Negativ	re Positiv	ve, CXR Positive	Positive, Treated
Low	Quantiferon	Results:	Negative	Positive		Positiv	ve, 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	1st Test Date:	1 st Result:	Normal	Abnormal Developmental	,		1st 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:	I	erum/Finger Lead Level:
HGB/HCT Test Date:			HGB/	HCT Result:				

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 1 2 3 4 Haemophilus influenza Type b (Hib) 1 2 3 4 Hepatitis B (HepB) 1 2 3 4 Polic (IPV, ORV) 1 2 3 4							
DT (<7 yrs.)/ Td (>7 yrs.) 1 2 3 4 5 Tdap Booster Haemophilus influenza Type b (Hib) 1 2 3 4 Hepatitis B (HepB) 1 2 3 4							
Tdap Booster Haemophilus influenza Type b (Hib) Hepatitis B (HepB) Tdap Booster 1 2 3 4 Hepatitis B (HepB)							
Haemophilus influenza Type b (Hib) 1 2 3 4 Hepatitis B (HepB) 1 2 3 4							
Hepatitis B (HepB) 1 2 3 4							
Tiepatitis B (Tiepb)							
Polic (IDV ODV)							
Polio (IPV, OPV) 1 2 3 4							
Measles, Mumps, Rubella (MMR) ¹ ²							
Measles ¹ ²							
Mumps ¹ ²							
Rubella ¹ ²							
Varicella ¹ Child had Chicken Pox (month & year):							
Pneumococcal Conjugate ¹ ² ³ ⁴							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
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 shild is helpind on inconvenientions and thous is a plan in place to set him /hou healt on set adule. Next are sintered in							
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 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:							
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: 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.

Dart 1. Student Information (To	ha completed by par	cont /quardian)		
Part 1: Student Information (To First Name School or Child Care Facility Name Date of Birth (MMDDYYYY)	Last Name		Middle Init	tial
School Day- Grade care Pre-K3 Pre-K4 1	2 3 4 5	6 7 8 9	10 11	Adult 12 Ed.
Part 2: Student's Oral Health Sta	tus (To be completed	d by the dental pro	vider)	
Q1 Does the patient have at least one tooth include stained pit or fissure that has no appointmental demineralized lesions (i.e. white spots).			Yes	No
Q2 Does the patient have at least one treat composite, temporary restorations, or crown				
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 patien untreated or treated with fillings/crown		ies that are either	Total Number	
Q7 How many of permanent teeth in the pa untreated, treated with fillings/crowns,	-	caries that are either	Total Number	
Q8 What type of dental insurance does the	patient have? Medic	aid Private Insurance	Other	None
Dental Provider Name		Der	ital 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.





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 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. 							
or 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 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:	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:					