

GOVERNMENT OF THE DISTRICT OF COLUMBIA 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 Person	nal Informat	i on To be	complet	ed by parer	nt/guardiar	1.					
Child Last Name:	Ch	ild First Nan	ne:		Date of Birth:						
School or Child Care Facili	ty Name:					Gender:	☐ Male	e 🔲	Female	☐ No	n-Binary
Home Address:				Apt:	City:		!	State:		ZIP:	
Ethnicity: (check all that apply)	Hispar	nic/Latino	Non-H	lispanic/Non	-Latino		Other		Prefer n	ot to ans	wer
Race: (check all that apply)		can Indian/ Native	Asian		Native Hawa Pacific Island		Black/Africa American	ın 🗖	White		Prefer not to answer
Parent/Guardian Name:					Pa	rent/Guardia	n Phone:				
Emergency Contact Name	:				En	nergency Con	tact Phone:				
Insurance Type:	edicaid \Box	Private \Box	None	Insurance	Name/ID #:						
Has the child seen a denti	st/dental provi	der 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 Healt		xam, and F	Recomr	nendatio	ns To be		by licensed	healt	n care pro	vider.	
Date of Health Exam:	BP:	, <u> </u>		eight:	LI KG	Height:			MI:	ВМІ	entile:
Vision Screening: Left eye: 20/_	Right e	ye: 20/_		Corrected Uncorrect			Vears glasse	es 🗖	Referred		Not tested
Hearing Screening: (check all	l that apply			Pass	Fail		Not tested		Uses Devi	ce 🔲	Referred
Asthma Autism Behavioral Cancer Cerebral palsy Developmental Diabetes Provide details. If the child	Failure to thrive Heart failure Kidney failure Language/Spee Obesity Scoliosis Seizures	e	Sickle cel Significar Details pro Long-tern Details pro Significar Details pro Other:	nt food/medi ovided below. m medication ovided below. nt health hist ovided below.	cation/envious, over-the	ronmental alle -counter-drug on, communic	ergies that n s (OTC) or s able illness,	pecial c	are require	ments.	_
TB Assessment Positiv	e TST should be	referred to Prin	nary Care	Physician for	evaluation. F	or questions c	all T.B. Contr	ol at 20	2-698-4040) <u>.</u>	
What is the child's risk le		Skin Test Date:		<u> </u>			iferon Test				
High complete skin to and/or Quantiferon test Quantiferon Quantiferon		ts:	Negative	Positive	e, CXR Negative	CXR Negative Positive, CXR Positive Positive, Treated					
		Quantiferon					Positive, Treated				
Additional notes on TB te		Results:		Negative	Positive		Pos	itive, i re	eated		
				DC CI-11-11	d I d D.	. i i D	-ti C-II 20	2 654	2002	202 525 2	2607
Lead Exposure Risk Scr	eening Allies	1st Re		1		-	ition. Call 20	12-054-6		202-535-2 um/Finge	
ONLY FOR CHILDREN UNDER AGE 6 YEARS		1 1/6		Normal	Abnorm Development	al, al Screening Da	te:			ead Leve	
Every child must have		<u> </u>		•					_		
2 lead tests by age 2	2 nd Test Date:	2 nd Re	esult:	Normal	Abnorm Development	al, al Screening Da	te:		I	rum/Fing .ead Leve	

Part 3: Immunization Information	1 To be com	pleted by licer	ised nealth car	e provider.				
Child Last Name:	Child First Name:				Date of Birth:			
Immunizations	In the boxes b			nunization (MM	/DD/YY)		ı	
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)		2	3	4				
Hepatitis B (HepB)		2	3	4				
Polio (IPV, OPV)		2	3	4				
Measles, Mumps, Rubella (MMR)		2						
Measles		2						
Mumps	1	2						
Rubella	1	2						
Varicella	1	2	Child had Chick Verified by:	en Pox (month &	k year):	(name	e & 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)	1	2	3	4	5	6	7	
Other	1	2	3	4	5	6	7	
The child is behind on immunizations ar	nd there is a plar	n in place to get	him/her back or	schedule. Next	appointment is	:		
	nd there is a plan	n in place to get	him/her back or	n schedule. Next	appointment is	:		
Medical Exemption (if applicable) I certify that the above child has a valid medic					appointment is	:		
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Medical Exemption (if applicable) I certify that the above child has a valid medic Diphtheria Tetanus Per Mumps Rubella Var	al contraindicat	ion(s) to being i	mmunized at the	e time against:	Polio	☐ Me		
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