DC | HEALTH

Certificat universel de santé

Utilisez ce formulaire pour informer l'école/garderie de l'état de santé de votre enfant. Ceci est une obligation en vertu du paragraphe §38-602 du Code officiel de DC. Faites remplir la partie 2 à 4 par un professionnel de la santé autorisé. Accédez aux programmes d'assurance santé au https://dchealthlink.com. Contactez le personnel du Bureau de santé par le biais du secrétariat de l'école.

Partie 1: Informations relatives à l'élève | À remplir par le parent ou tuteur.

Nom de l'enfant :	**Prénom de l'enfant :**	**Date de naissance :**
Nom de l'établissement scolaire ou de la garderie :	**Sexe :** ❑ Homme ❑ Femme ❑ Non-binaire	
Adresse :	**Appartement :** **Ville:**	**État :** **Code postal :**

Origine ethnique : *(cocher la case correspondante)* ❑ Latino-hispanique ❑ Non Latino-hispanique ❑ Autre ❑ Préfère ne pas répondre

Race : *(cocher la case correspondante)* ❑ Amérindien/ autochtone de l'Alaska ❑ Asiatique ❑ Natif d'Hawaï/ Insulaires du Pacifique américain ❑ Noir/Africain ❑ Blanc ❑ Préfère ne pas répondre

Nom du parent ou tuteur :	**Numéro de téléphone du parent ou tuteur :**
Nom du contact en cas d'urgence :	**Numéro de téléphone du contact en cas d'urgence :**
Type d'assurance : ❑ Medicaid ❑ Privée ❑ Aucune	**Nom de l'assurance/n° ID :**

L'enfant a-t-il consulté un dentiste au cours de l'année écoulée ? ❑ Oui ❑ Non

J'autorise l'examinateur ou l'établissement de santé signataire à partager les informations de santé figurant sur ce formulaire avec l'école, le service de garde, le campement ou l'organisme gouvernemental concerné de mon enfant. Par ailleurs, je reconnais et accepte par les présentes qu'en vertu de la loi 17-107 de DC, la municipalité, l'école, ses employés et agents sont exempts en matière de responsabilité civile en ce qui concerne les actes ou omissions, à l'exception des actes délictueux, des actes répréhensibles intentionnels, des négligences graves, ou des fautes délibérées. Je comprends que ce formulaire doit être rempli et renvoyé à l'école de mon enfant chaque année.

Signature du parent ou tuteur :____ **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 ❑	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/________ Right eye: 20/__________ ❑ Corrected ❑ 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 ❑ Failure to thrive ❑ Sickle cell
❑ Autism ❑ Heart failure ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
❑ Behavioral ❑ Kidney failure
❑ Cancer ❑ Language/Speech ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
❑ Cerebral palsy ❑ Obesity
❑ Developmental ❑ Scoliosis ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
❑ Diabetes ❑ Seizures ❑ **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?	**Skin Test Date:**	**Quantiferon Test Date:**
❑ High → *complete skin test and/or Quantiferon test*	**Skin Test Results:** ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated	
❑ Low	**Quantiferon Results:** ❑ Negative ❑ P ❑ 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.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide 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): 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: _________________________

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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:**

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:**