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

Date of Health Exam: BP: \_\_/ \_\_ NML Weight: \_\_ LE Height: \_\_ IN BMI: BMI Percentile: \_\_

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ Corrected \_\_ Uncorrected \_\_

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
- Developmental
- Diabetes
- 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: Skin Test Results: Negative Positive, CXR Negative Positive, CXR Positive Positive, Treated

Skin Test Results: Negative Positive, Treated

Quantiferon Results: Negative 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.**

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>In the boxes below, provide the dates of immunization (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis (DTP, DTaP)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>DT (&lt;7 yrs.)/ Td (&gt;7 yrs.)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Tdap Booster</td>
<td>1</td>
</tr>
<tr>
<td>Haemophilus influenza Type b (Hib)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Polio (IPV, OPV)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1 2</td>
</tr>
<tr>
<td>Measles</td>
<td>1 2</td>
</tr>
<tr>
<td>Mumps</td>
<td>1 2</td>
</tr>
<tr>
<td>Rubella</td>
<td>1 2</td>
</tr>
<tr>
<td>Varicella</td>
<td>1 2</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Hepatitis A (HepA) (Born on or after 01/01/2005)</td>
<td>1 2</td>
</tr>
<tr>
<td>Meningococcal Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Influenza (Recommended)</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Rotavirus (Recommended)</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

- ☑ 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.

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.

<table>
<thead>
<tr>
<th>Licensed Health Care Provider Office Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Provider Phone:</td>
</tr>
<tr>
<td>Provider Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>School Official Name:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Suite Personnel Name:</td>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>