DC HEALTH 通用健康证书

使用此表格向您子女的学校/儿童保育机构报告您子女的身体健康状况。这是哥伦比亚特区官方法典第38-602条所要求的。由持证医疗专业人士填写第2部分至第4部分。如需获取健康保险计划，请访问：https://dchealthlink.com。您可以通过您子女所在学校的总务处联系Health Suite工作人员。

第1部分：子女个人信息| 由家长/监护人填写。

孩子姓氏：	**孩子名字：**	**出生日期：**
学校或托儿机构名称：	**性别：** ❑ 男 ❑ 女 ❑ 非二元性别	
家庭地址：	**公寓：** **城市：** **州：**	**邮编：**
民族（*勾选所有适用的选项*）	❑ 西班牙裔/拉丁裔 ❑ 非西班牙裔/非拉丁裔 ❑ 其他 ❑ 不想回答	
种族：（*勾选所有适用的选项*）	❑ 美洲印第安人/阿拉斯加原住民 ❑ 亚裔 ❑ 夏威夷原住民/太平洋岛民美国 ❑ 黑人/非裔 ❑ 白人 ❑ 不想回答	
家长 / 监护人姓名：	**家长 / 监护人电话：**	
紧急联系人姓名：	**紧急联系人电话：**	
保险类型： ❑ Medicaid ❑ 私营保险 ❑ 无	**保险名称 / 身份识别号：**	
孩子去年是否看过牙医/牙科服务提供者？ ❑ 是 ❑ 否		

我允许签署本表格的健康检查人员/机构向我子女的学校、托儿所、营地或相应的哥伦比亚特区政府机构披露此表格上的健康信息。此外，我在此确认和同意，除犯罪行为、故意违法行为、重大过失或故意不当行为外，哥伦比亚特区、学校及其工作人员和代理人根据哥伦比亚特区法律第17-107规定对于任何作为或不作为均不承担民事责任。我知道本表格应每年填写并交回我子女的学校。

家长 / 监护人签名： _____ **日期：** _____

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
- ❑ Developmental
- ❑ 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.

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: _____

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: