Universal Health Certificate

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

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 dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.				
Child Last Name:	**Child First Name:**		**Date of Birth:**	
School or Child Care Facility Name:		**Student Grade Level:**	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:**	**City:**	**State:**	**Zip:**
Ethnicity: *(check all that apply)* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer				
Race: *(check all that apply)* ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer				
Parent/Guardian Name:		**Parent/Guardian Phone:**		
Emergency Contact Name:		**Emergency Contact Phone:**		
Insurance Type: ☐ Medicaid ☐ Private ☐ None		**Insurance Name/ID #:**		
Has the child seen a dentist/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: _____

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:** ☐ LBS ☐ KG	**Height:** ☐ IN ☐ CM	**BMI:**	**BMI Percentile:**
Vision Screening Acuity Level: For Children 3–6 years of age, only a (Pass/Fail) will be required. Those age 6 years and over will require vision acuity levels for this section.					
Vision Screening: Left eye: 20/_____ L: ☐ Pass ☐ Fail	Right Eye: 20/_____ R: ☐ Pass ☐ Fail	☐ Corrected ☐ Uncorrected	☐ Wears glasses	☐ Referred	☐ Not tested
Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not Tested ☐ Uses Device ☐ Referred					

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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 TB tests should be referred to Primary Care Provider for evaluation. For questions call DC Health TB Control at 202-698-4040. Visit dchealth.dc.gov/page/tuberculosis-basics for more information on Tuberculosis.

What is the child's risk level for TB?	**Skin Test Date:**	**IGRA Blood Test Date:**
☐ High > *complete skin test and/or IGRA blood test* ☐ Low	**Skin Test Results:** ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated	**IGRA 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) 481-3837 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:**
	3rd Test Date:	**3rd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**3rd Serum/Finger Stick Lead Level:**

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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						
DTaP-IPV	1	2					
DTap-IPV-Hib	1	2	3				
DTap-HepB-IPV	1	2	3				
DTap-IPV-Hib-HepB	1	2	3				
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					
Human Papillomavirus (HPV)	1	2	3				
Meningococcal Vaccine (ACWY)	1	2					
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
COVID-19 (Recommended)	1	2	3	4	5	6	7
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/them back on schedule.
Next appointment is: _____

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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 (All 3 serotypes) ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal (ACWY) ☐ HPV
☐ COVID-19

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 (All 3 serotypes) ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ 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 i**n 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.** ☐ NA ☐ 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:**