CONFIDENTIAL FORM-SIDE ONE *PLEASE REVIEW INSTRUCTIONS ON SIDE TWO*

DISTRICT OF COLUMBIA CHILD HEALTH CERTIFICATE

Part 1: Child's Personal Information ***Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 6 below.***

Child's Last Name	*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*Race/Ethnicity:* ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____
Parent or Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward*
Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zipcode:*
School or child care facility:	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____			*Primary Care Provider (PCP):*

Part 2: Child's Health History, Examination & Recommendations. **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	HGB / HCT *(Required for Head Start)*

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Dental-Oral Health	☐ None	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ None	☐ YES	☐ Referred ☐ Under Rx
Asthma	☐ None	☐ YES	☐ Referred ☐ Under Rx	Vision	☐ None	☐ YES	☐ Referred ☐ Under Rx
Development	☐ None	☐ YES	☐ Referred ☐ Under Rx	Hearing	☐ None	☐ YES	☐ Referred ☐ Under Rx
Behavioral/Emotional	☐ None	☐ YES	☐ Referred ☐ Under Rx	Nutrition	☐ None	☐ YES	☐ Referred ☐ Under Rx
Learning/Attention	☐ None	☐ YES	☐ Referred ☐ Under Rx	Neurologic	☐ None	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, childcare, sports, or camp.
☐ NONE ☐ YES, please detail:

B. Significant allergies or health conditions that may require ***emergency medical care*** at school, childcare, camp, or sports activity.
☐ NONE ☐ YES, please detail:

C. Long-term Medications or special care requirements or accommodations.
☐ NONE ☐ YES, please detail: (Please specify medication dosage/time/administration instructions and common side effects if given at school/child care)

This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or childcare activities except as noted above. **ATHLETE IS CLEARED FOR COMPETITIVE SPORTS: ☐ YES ☐ NO**

Part 3: Immunization Information: ***(Please fill in or attach equivalent copy with provider signature and date)***

Diphtheria-Tetanus-Pertussis (< 7 yrs)	DTP/DTaP-1	DTP/DTaP-2	DTP/DTaP-3	DTP/DTaP-4	DTP/DTaP-5
Diphtheria-Tetanus (DT <7 yrs must have P exemption) (Td >7 yrs)	DT/Td -1	DT/Td -2	DT/Td –3	DT/Td -4	DT/Td-5
Hemophilus Influenzae B (HIB)	HIB1	HIB2	HIB3	HIB4	
Hepatitis B (HBV)	HBV1	HBV2	HBV3		
Polio	OPV/IPV- 1	OPV/IPV- 2	OPV/IPV-3	OPV/IPV- 4	
Measles-Mumps-Rubella (MMR)	MMR1	MMR2	Measles-1_____ Measles-2_____	Mumps-1_____ Mumps-2_____	Rubella-1_____ Rubella-2_____
Varicella	VZV1	VZV2	☐ Check if hx disease Disease date _____		
Influenza (not required)	FLU-1	FLU-2	FLU-3	FLU-4	FLU-5
Pneumococcal conjugate (PCV7)	PCV7-1	PCV7-2	PCV7-3	PCV7-4	
Other					

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing If PPD Positive:

TB EXPOSURE RISKS? See reverse side for instructions.	☐ HIGH→ ☐ LOW	PPD TEST DATE:	☐ NEGATIVE ☐ POSITIVE	☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ **TREATED**	**Health Provider:** ALL POSITIVE PPD tests MUST BE Reported to T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS? See reverse side for instructions.	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels MUST BE Reported to DC Division of Lead Poisoning Prevention: Fax: 202-535-1398	

Part 5: Required Provider Certification and Signature

Age-Appropriate Health Screening Requirements Performed Within Current Year ☐ YES ☐ NO
If NO, please explain

Medical Exemption From Immunization: I hereby certify that the student named above was not immunized against (disease) _____ because (reason) _____ (if applicable, attach serological test results). Date Exemption Expires: _____

Print Name	MD/NP Signature	*Date*
Address	*Phone*	*Fax*

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, childcare, camp, or DOH

PRINT NAME	SIGNATURE	Date

Top Copy – School Nurse **2nd Copy – School** **3rd Copy – Parent** 7/18/2006

This form r*eplaces* all forms dated before February 25, 2004, used for entry into DC Schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form, formally the Dental Appraisal Form. This form was developed by the DC Department of Health and follows American Academy Of Pediatrics (AAP) Guidelines For Child And Adolescent Health Care Birth to 21 Years Of Age. **This form is a confidential document.** Confidentiality is adherent to *The Health Insurance Portability and Accountability Act of 1996* (HIPAA) for the health providers, and *The Family Educational Rights and Privacy Act* (FERPA) for the DC Schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's personal information:

Parent or Guardian: Please check the box that best fits the description of the child's race or ethnicity. Please indicate the ward of your home address. List primary care provider and type of health insurance coverage. If child has no provider or is uninsured, then please write **"None"** in each box. **This form will not be complete without parent or guardian signature in Part 5.**

Part 2: Child's health history, Examination & Recommendations: To be completed by the health care provider. Please mark all relevant boxes.

- **Date of complete health exam**: **All children MUST have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines.** The date entered here must indicate that the child is in compliance with these requirements outlined in DC Law 6-66.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG) **HT: Child's height in either inches (IN) or centimeters (CM)**
- **BP: If child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal please provide explanation and resolution in part 2 section "A."**
- **HGB/HCT:** Hemoglobin (HGB) o**r** Hematocrit (HCT) is r*equired* For Head Start children. Anemia screen is recommended for menstruating adolescents based on AAP guidelines. Please record level and indicate by circling HGB or HCT.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens dental-oral health, asthma, development, behavioral/emotional, learning/attention, language/speech, vision, hearing, nutrition, and "neurologic disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO "HEALTH CONCERNS" then please mark the **'None'** Box in each screen area. **SPECIAL NOTE: 'Dental-Oral Health' refers to the screening done by a primary care provider. This does not replace a comprehensive oral examination provided by a dentist. For children age three and older the health care provider must also indicate whether dentist has screened or examined the child within the last 12 months. If no, child should be referred to dentist.**

A. Please note any significant health history, conditions, communicable illness, or restrictions that may affect the activity or program **OR mark 'NONE'.**
B. Please note any significant allergies or health conditions that may require ***emergency medical care*** at the activity or program **OR mark 'NONE'**
C. Please note any long-term medications or special care requirements or accommodations **OR mark 'NONE'**. (For medications that require administration at activity or program, please specify dosage/ timing / administration instructions and common side effects of each medication).
Athlete is cleared for competitive sports based on the assessment in the AAP Preparticipation Physical Evaluation 2nd Ed. (1997): Check YES or NO. This will cover patient for ALL YEARLY PHYSICALS for competitive sports.

Part 3: Immunization Information:

All areas of this section must be completed or an equivalent form attached with the physician's or health care provider's signature.
As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised 03/21/97), the following immunizations are required. Medical exemptions from immunizations may be granted for valid reasons with proper documentation and certified and signed by the health care provider in Part 5.
DOH Immunization Program: 202-576-7130

Age of Child	DTaP/DTP/DT/Td[2]	Polio[3]	Hib[4]	Hepatitis B	Pneumoccal[7]	MMR[5]	Varicella[6]
Less than 2 Months	0	0	0	0	0	0	0
2-3 Months	1	1	1	1	1	0	0
4-5 Months	2	2	2	2	2	0	0
6-11 Months	3	3	3	3	3	0	0
12-17 months	4	3	3 or 4	3	4	1	1
18-60 Months	4	3	3 or 4	3	4	1	1

Summary of **REQUIRED** Cumulative Number of Doses of Vaccine for Children in GRADES KINDERGARTEN – 12[1] Doses Must Be Appropriately Spaced and Given at Appropriate Age

Grade Level		DTaP/DTP/DT/Td[2]					
Grade	If Ungraded		Polio[3]	Hib[4]	Hepatitis B	MMR[5]	Varicella[6]
Kindergarten	(5 years)	5	4	Not required	3	2	1
Grades 1 & 2	(6-7 years)	5	4	Not required	3	2	1
Grades 3 - 5	(8-10 years)	5 doses or ≥3 doses Td	4	Not required	3	2	1
Grades 6 – 12	(11-18+ yrs)	5 doses or ≥3 doses Td plus 1 Td booster if 10 years since last dose	4	Not required	3	2	<13 yrs = 1 dose > 13 yrs = 2 doses

All religious exemptions must be submitted to the school Principal & must be accompanied by a signed notarized statement from parent or guardian. Child care and Head Start children must obtain exemptions from child care or Head Start Director.

[2] DTaP/DTP/DT/Td: 5 doses of DTaP/DTP are required for school entry unless the fourth dose is given on or after the 4th birthday. Three (3) doses of Td required if primary series started after 7th birthday. Td booster required every 10 years.
[3] Polio: Four doses are required for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which case only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are always required to complete the primary series. Polio not routinely required for students >18 years of age.
[4] Hib: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age; however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.
[5] MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and varicella must be given on the same day or separated by at least one month.
[6] Varicella: The varicella vaccine is not required for a student who has a reliable history of disease. One dose is required for students 12 years old or younger at the time of vaccination. If students is ≥13 years of age at time of vaccination, 2 doses are required. MMR and varicella must be given on the same day or at least one month apart.
[7] Pneumococcal Vaccine: Recommended for all children age 2 to 23 months. The number of primary doses is determined by age series begins. The final dose in the series should be given at age > 12 months. It is also recommended for certain children age 24 to 59 months.

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing:

- **TUBERCULOSIS EXPOSURE RISKS?** Please assess risk of ALL patients for **Exposure to Tuberculosis** as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2003 AAP RED BOOK page 646.* **Current DC regulations require ONE** PPD (Purified Protein Derivative) Test for all children entering child care or school, whichever comes first. PPD Test is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note date of test and mark outcome of test (negative or positive). **IF PPD IS POSITIVE,** then mark outcome of chest X-Ray (CXR) and if child was treated. **ALL POSITIVE PPD tests MUST BE Reported to DC T.B. Control at 202-698-4040.**
- **LEAD EXPOSURE RISKS?** Please assess risk of ALL patients for exposure to lead using the *AAP Statement " Screening for Elevated Blood Lead Levels" (1998).* All children require a lead test between 9 and 12 months of age and again at 24 months of age. All children between 26 months and 6 years who have not had a lead test require at least **ONE** documented lead test unless assessed as HIGH RISK OF EXPOSURE. Please document "Date" of most recent test and "Result". Please indicate if "Pending". "Pending" results will be **valid for two months from date of testing** and will NOT exclude child from activity or program. **ALL lead tests must be reported to DC Lead Poisoning Prevention by Fax: at 202-535-1398.**

Part 5: Required Provider Certification and Signature

All information will be kept confidential. A physician or nurse practitioner must complete this part. By checking the yes box the provider certifies that the child has received age-appropriate screenings according to AAP and EPSDT guidelines within the current year. If no is checked please explain reason in space provided.

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

- **The parent or guardian must print, sign, and date this Part.** By signing this section the parent or guardian gives permission to the health examiner or facility to share the health information on this form with the child's school, childcare, camp, DOH, or the entity requesting this document.