DC HEALTH Certificado Universal de Salud

Use este formulario para informar sobre la salud física de su hijo a su escuela/centro de cuidado infantil. Esto es requerido por la Sección 38-602 del Código Oficial del Distrito de Columbia. Pida a un profesional médico autorizado que complete las partes 2 a 4. Acceda a los programas de seguro de salud en https://dchealthlink.com. Puede comunicarse con el personal de la sala de salud a través de la oficina principal de la escuela de su hijo.

Parte 1: Información personal del niño | A ser completada por el padre/tutor.

Apellido del niño:	**Nombre del niño:**	**Fecha de nacimiento:**
Nombre de la escuela o centro de cuidado infantil:	**Sexo:** ❑ Masculino ❑ Femenino ❑Ninguno de los dos anteriores	

Dirección residencial:	**Apartamento:**	**Ciudad:**	**Estado:**	**CÓDIGO POSTAL:**

Etnia *(marque todo lo que corresponda)* ❑ Hispano/latino ❑ No hispano/no latino ❑ Otro ❑ Prefiere no responder

Raza: *(marque todo lo que corresponda)* ❑ Indio americano/ nativo de Alaska ❑ Asiático ❑ Hawaiano nativo / Americano de otra Isla del Pacífico ❑ Negro/africano ❑ Blanco ❑ Prefiere no responder

Nombre del padre/tutor:	**Teléfono del padre/tutor:**
Nombre de contacto en caso de emergencia:	**Teléfono de contacto en caso de emergencia:**
Tipo de seguro: ❑ Medicaid ❑ Privado ❑ Ninguno	**Nombre/N.º de identificación del seguro:**

¿Ha visto el niño a un dentista/proveedor de servicios odontológicos en el último año? ❑ Sí ❑ No

Autorizo al examinador médico/centro de salud que firma para compartir la información médica en este formulario con la escuela, el centro de cuidado infantil, el campamento de mi hijo o la agencia gubernamental del Distrito de Columbia correspondiente. Asimismo, por el presente, reconozco y acepto que el Distrito, la escuela, sus empleados y agentes tendrán inmunidad frente a toda responsabilidad civil por actos u omisiones de acuerdo con la Ley 17-107 del Distrito de Columbia, excepto por actos criminales, actos ilícitos intencionales, negligencia grave o mala conducta intencional. Entiendo que este formulario debe completarse y devolverse a la escuela de mi hijo todos los años.

Firma del padre/tutor:_____ **Fecha:**_____

Parte 2: Child's Health History, Exam and Recommedations| To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ___ / ____	❑ NML ❑ ABNL	**Weight:**	❑ LB ❑ KG	**Height:**	❑ IN ❑ CM	**BMI:**	**BMI Percentil:**

Vision Screening Left eye: 20/:_____ Right eye: 20/_____ ❑ Pass ❑ Fail ❑ **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
- ❑ Scolliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/enviornmental allergies that may require emergency medical cate. *Details Provided below*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements *Details Povided below*
- ❑ Significant health history, condition, comunicable illness, or restructions *Details provided below.*
- ❑ **Other:**_____

Provided details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment 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 of 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 the DC Childhood Lead Poisioning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 elad 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:**

Parte 3: Immunization Information | To be completed by licensed health care provider.

Child's Last Name:	**Child's First Name:**	**Date of Birth:**

Immunizations	**In the boxes below, provide the dates of immunization (MM/DD/YY)**						
Diptheria, 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, Munps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month &year): Verifiied by: _____(name &title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005	1	2					
Megningoccal 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 contraindication (s) to being immunized at the time against

❑ Diptheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles

❑ Munps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

¿Is this medical contraindication permanent or temporary? ❑ Permanent ❑ Temporal 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 ❑ Pneumoccoccal ❑ HepA ❑ Meningococcal ❑ HPV

Parte 4: Liscensed 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 ❑ YEes

Este niño está autorizado para realizar **competitive sports.** ❑ N/C ❑ No ❑ YEs ❑ Yes, pending additional clearance form:_____

I hearby certify that I examined this child and the information recorded here was deteremined 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 Office Name:	**Signature:**	**Date:**
Health Suite Personnel Name:	**Signature:**	**Date:**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.