DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Universal Health Certificate

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 https://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:	**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:** ❑ 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				
Coronavirus (COVID)	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 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
☐ COVID-19

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until:_____(date)

Reason for the medical exemption:_____

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 childcare 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:

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Oral Health Assessment Form

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

Instructions

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

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

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Student ID _____ Date of Birth (MMDDYYYY): ☐☐/☐☐/☐☐☐☐

Current Gender Identity: _____

Home Address: _____ Home State: ____ Home Zip Code ☐☐☐☐☐

School Grade	Day-care	Pre-K3	Pre-K4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

	Yes	No
1. 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).	☐	☐
2. 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.	☐	☐
3. Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
4. Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
5. Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

6. How many **primary teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns?** ☐☐
7. How many **permanent teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns** ☐☐
   - **c. Extracted due to caries?** ☐☐
8. What type of dental insurance does the patient have? Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____ Dental Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and childcare 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.