

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 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		
Home Address:				Apt:	City:		State:	Zip:	
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer									
Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer									
Parent/Guardian Name:					Parent/Guardian Phone:				
Emergency Contact Name:					Emergency Contact Phone:				
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None					Insurance Name/ID #:				
Has the child seen a dentist/dental provider within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ <input type="checkbox"/> NML <input type="checkbox"/> ABNL		Weight: _____ <input type="checkbox"/> LBS <input type="checkbox"/> KG		Height: _____ <input type="checkbox"/> IN <input type="checkbox"/> 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/____ Right Eye: 20/____		<input type="checkbox"/> Corrected <input type="checkbox"/> Wears glasses		<input type="checkbox"/> Referred <input type="checkbox"/> Not tested			
		L: <input type="checkbox"/> Pass <input type="checkbox"/> Fail R: <input type="checkbox"/> Pass <input type="checkbox"/> Fail		<input type="checkbox"/> Uncorrected					
Hearing Screening: (check all that apply) <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Tested <input type="checkbox"/> Uses Device <input type="checkbox"/> Referred									

Does the child have any of the following health concerns? (check all that apply and provide details below)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. <i>Details provided below.</i> |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. <i>Details provided below.</i> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Language/Speech | <input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. <i>Details provided below.</i> |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | |

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?

- ☐ High > complete skin test and/or IGRA blood test
- ☐ Low

Skin Test Date:

- Skin Test Results:**
- ☐ Negative
- ☐ Positive, CXR Negative
- ☐ Positive, CXR Positive
- ☐ Positive, Treated

IGRA Blood Test Date:

- 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 **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**. ☐ 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: