# DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

**Part 1: Child's Personal Information** **Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 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: | Telephone: ☐Home ☐Cell ☐Work. | Home Address: | | | Ward: |
| Emergency Contact Person: | Emergency Number: ☐Home ☐Cell ☐Work | City/State (if other than D.C.) | | | Zip code: |
| School or Child Care Facility: | ☐Medicaid ☐Private Insurance ☐None Name/ID Number_____ | Primary Care Provider (PCP): | | | |

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

| DATE OF HEALTH EXAM: | | | WT ☐LBS ☐KG | HT ☐IN ☐CM | BP: [>3yrs] ☐NML ☐ABNL | Body Mass Index [>2 yrs] (BMI)_____ %_____ |
|---|---|---|---|---|---|---|
| HGB / HCT *(Required for children under age 6)* | | | Vision Screening Right 20/____ Left 20/____ | ☐Glasses ☐Referred ☐Attempted | Hearing Screening Pass_____ Fail_____ | ☐Device ☐Referred ☐Attempted |

| HEALTH CONCERNS: | | | REFERRED or TREATED | HEALTH CONCERNS: | | | REFERRED or TREATED |
|---|---|---|---|---|---|---|---|
| Asthma | ☐ NO | ☐ YES | ☐Referred ☐Under Rx | Language/Speech | ☐ NONE | ☐ YES | ☐Referred ☐Under Rx |
| Seizures | ☐ NO | ☐ YES | ☐Referred ☐Under Rx | Development/ Behavioral | ☐ NONE | ☐ YES | ☐Referred ☐Under Rx |
| Diabetes | ☐ NO | ☐ YES | ☐Referred ☐Under Rx | Other_____ | ☐ NONE | ☐ YES | ☐Referred ☐Under Rx |

**ANNUAL DENTIST VISIT**: Has the child seen a Dentist/Dental Provider within the last year? ☐YES ☐NO ☐Referred ☐**Fluoride Varnish** Date:_____

**A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.**
**☐ NONE ☐ YES, please provide details:**

_____

_____

**B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.**
**☐ NONE ☐ YES, please provide details:**

_____

_____

**C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements. ☐ NONE ☐ YES, please provide details. (For any medications or treatment required during school hours, a Licensed Health Practitioner's Medication Plan or Medication Authorization Order should be submitted with this form).**

_____

_____

**Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:**

| TB RISK ASSESSMENTS | ☐ HIGH→ ☐ LOW | Tuberculin Skin Test (TST) DATE: | ☐ NEGATIVE ☐ **POSITIVE** | If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED | **Health Practitioner:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: **202-698-4040** |
|---|---|---|---|---|---|
| LEAD EXPOSURE RISKS | **LEAD TEST DATE:** | | RESULT: | **Health Practitioner:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: **202-535-2607** | |

**Part 4: Required Licensed Health Practitioner's Certification and Signature**

**☐ YES ☐ NO This child has been appropriately examined & health history reviewed and recorded in accordance with the items specified on this form. At time of the exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.**

**☐ YES ☐ NO This athlete is cleared for competitive sports.**

**☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:**

_____

_____

| Print Name | MD/APRN/NP Signature | | Date |
|---|---|---|---|
| Address | | Phone | Fax |

**Part 5: Required Parental/Guardian Signatures. (Release of Health Information/civil liability waiver)**

*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.*

# DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

**Student Last Name:** **Student First Name:** **DOB:**

**Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's signature and date.**

| IMMUNIZATIONS | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Practitioner) 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 | | | | |
| Other | | | | | | | |

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

**Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner Use Only.**

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

**Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner or Health Official.**

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
# EDUCATION

***DIVISION OF EARLY LEARNING***
***Licensing and Compliance Unit***

## AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
**(Update Annually)**

If my child _____, born on _____/_____/_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ❑ DC ❑MD ❑VA

Child's known Allergies or Physical Conditions: _____
_____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

**Place in child's folder/record.**

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# TRAVEL AND ACTIVITY AUTHORIZATION

❑ Special one time permission for this activity only ❑ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

**Trips in the van/automobile** (facility or parent - owned)

_____
Explain planned activity - where and when

**Field trips away from the facility**

_____
Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

❑ I will allow my child to play outside the fenced area; or

❑ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

**PLEASE KEEP A COPY IN THE CHILD'S FILE.**

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
# EDUCATION

## REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

**Child:** _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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**Relative or Guardian:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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**Person to be contacted in case of an emergency (other than parent/guardian):**

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

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**Designated individual authorized to receive child at end of session:**

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

---

**Signature:** _____ **Relationship to child:** _____ **Date:** _____

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***TO BE COMPLETED BY THE FACILITY***

**Date of Admission:** _____
**Date of Withdrawal:** _____ **Reason:** _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
# EDUCATION

## Medication Authorization Form

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1; "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."*

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5,"A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log.*

### Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the following
*Name of Facility*

prescribed medication to my child _____ born on _____.

| Name of Medication | Time/Frequency | Dosage | Effective Dates | |
|---|---|---|---|---|
| | | | From: | |
| | | | To: | |
| | | | From: | |
| | | | To: | |

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

### Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:

| Name of Medication | Date | Time Given | Reactions | Staff Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PLEASE PLACE A COPY IN THE CHILD'S FILE.**

# District of Columbia Oral Health (Dental Provider) Assessment Form

DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

**Parent/Guardian Instructions:**
**Part 1:** Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
**Part 2:** By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

WE ARE WASHINGTON DC

## Part 1: Child's Personal Information (to be completed by the parent/guardian)

| | | | | |
|---|---|---|---|---|
| Child's Last Name: | Child's First & Middle Name: | Date of Birth: MM/DD/YYYY | Gender: ☐M ☐F | School or Child Care facility: Grade: |
| Parent/Guardian Name 1: | Telephone 1: ☐ Home ☐ Cell ☐ Work | Home Address: | | Ward: |
| Parent/Guardian Name 2: | Telephone 2: ☐ Home ☐ Cell ☐ Work | Emergency Contact: | | Telephone: |
| Race Ethnicity: ☐ White Non-Hispanic ☐ Black Non-Hispanic ☐ Hispanic ☐ Asia or Pacific Islander ☐ Other | | | | |
| Primary Care Provider (Medical): | Dentist/Dental Provider: | Type of Dental Insurance: ☐ Medicaid ☐ Private Insurance ☐ None ☐ Other | | |

## Part 2: Required Parent/Guardian Signatures

**Parent/Guardian Release of Health Information:**
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

**Dental Provider Instructions:**
**Part 3**: Indicate Circle Yes or No in finding column. For Yes, please explain in Comments Section.
**Part 4** Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

## Part 3: Child's Findings and Parent Recommendations (please indicate in finding column)

CONFIDENTIAL FORM

| | Findings | Comments |
|---|---|---|
| Gingival inflammation | Y N | |
| Plaque and/or calculus | Y N | |
| Abnormal gingival attachments | Y N | |
| Malocclusion | Y N | |
| Treated Dental Caries | Y N | |
| Untreated dental caries | Y N | ☐Check box if Urgent |
| Sealants on permanent molars | Y N | |
| Cleft lip and palate | Y N | |
| Preventative services completed | Y N | What kinds of preventative services were completed? ☐Prophy ☐Fluoride ☐Oral Hygiene |

## Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐is completed ☐is not completed ☐under treatment ☐refused treatment ☐no necessary.
The child has ongoing ☐urgent ☐non-urgent treatment needs and is under treatment ☐by me or ☐has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: **Phone:** **Date:**

**District of Columbia Health Certificate:**
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age or older have an oral health