



DISTRICT OF COLUMBIA CHILD 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: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____
Parent or Guardian Name	Telephone1: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Home Address:		Ward
Emergency Contact:	Telephone2: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	City/State (if other than D.C.)		Zipcode:
School or child care facility:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> 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	<input type="checkbox"/> LBS <input type="checkbox"/> KG	HT	<input type="checkbox"/> IN <input type="checkbox"/> CM	BP: _____ (>3 yrs) <input type="checkbox"/> NML <input type="checkbox"/> ABNL	HGB / HCT (Required for Head Start)
HEALTH CONCERNS:	REFERRED or TREATED		HEALTH CONCERNS:		REFERRED or TREATED	
Dental-Oral Health	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Language/Speech	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Asthma	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Vision	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Development	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Hearing	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Behavioral/Emotional	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Nutrition	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Learning/Attention	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Neurologic	<input type="checkbox"/> None <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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/D1aP-1	DTP/D1aP-2	DTP/D1aP-3	DTP/D1aP-4	DTP/D1aP-5
Diphtheria-Tetanus (D1 < 7 yrs must have P exemption) (1d > 7 yrs)	D1/Td-1/1dap-1	D1/Td-2	D1/Td-3	D1/Td-4	D1/Td-5
Tetanus-diphtheria-acellular pertussis (Tdap)					
Haemophilus 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	<input type="checkbox"/> Check if hx disease Disease date _____ (month/year)		
Pneumococcal conjugate (PCV7)	PCV7-1	PCV7-2	PCV7-3	PCV7-4	
Hepatitis A (HAV)	HAV-1	HAV-2			
Meningococcal (MCV4)	MCV-1				
Human Papillomavirus (HPV)	HPV-1	HPV-2	HPV-3		

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

TB EXPOSURE RISKS? See reverse side for instructions.	<input type="checkbox"/> HIGH→ <input type="checkbox"/> LOW	PPD TEST DATE:	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	<input type="checkbox"/> CXR NEGATIVE <input type="checkbox"/> CXR POSITIVE <input type="checkbox"/> 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.	<input type="checkbox"/> YES→ <input type="checkbox"/> NO	LEAD TEST DATE:	RESULT:	Health Provider: ALL lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-442-4827	

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
------------	-----------	------

This form **replaces 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) or Hematocrit (HCT) is *required* 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

Summary of REQUIRED Cumulative Number of Doses of Vaccine for PRESCHOOL aged children ¹						Doses Must Be Appropriately Spaced and Given at Appropriate Age			
Age of Child	DTaP/DTP/DT/Td ²	Polio ³	Hib ⁴	Hepatitis B	Hepatitis A (born after 01/01/05)	Pneumococcal ⁷	MMR ⁵	Varicella ⁶	
Less than 2 Months	0	0	0	0	0	0	0	0	
2-3 Months	1	1	1	1	0	1	0	0	
4-5 Months	2	2	2	2	0	2	0	0	
6-11 Months	3	3	3	3	0	3	0	0	
12-17 months	4	3	3 or 4	3	2	4	1	1	
18-60 Months	4	3	3 or 4	3	2	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	Polio ³	Hib ⁴	Hepatitis B	Hepatitis A (born after 01/01/05)	MMR ⁵	Varicella ⁶	MCV ('09-'10 School Year)	HPV ('09-'10 School Year)
Kindergarten (5 years)	5	4	Not required	3	2	2	2	0	0
Grades 1 & 2 (6-7 years)	5	4	Not required	3	2	2	2	0	0
Grades 3 - 5 (8-10 years)	5 doses or ≥ 3 doses Td	4	Not required	3	2	2	2	0	0
Grades 6 – 12 (11-18+ yrs)	5 doses plus Td/Tdap booster Or ≥ 3 doses OR if 10 years since last dose	4	Not required	3	2	2	2	1	3

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.

²DTaP/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.

³Polio: 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.

⁴Hib: 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.

⁵MMR: 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.

⁶Varicella: The varicella vaccine is not required for a student who has a reliable history of disease. Two doses are required for students 4 years old or older.

⁷Pneumococcal 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 SCREENING TESTS:** DC law requires that all children get tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6 years. 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 electronically by labs to DC Lead Poisoning Prevention Program. For detailed instructions, call 202-442-5876. Providers may fax to: 202-442-4827.**

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.

Forms are available online at www.dchealth.dc.gov