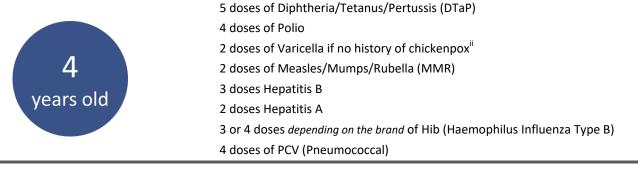
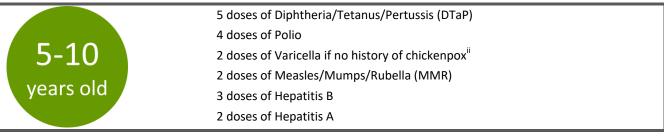
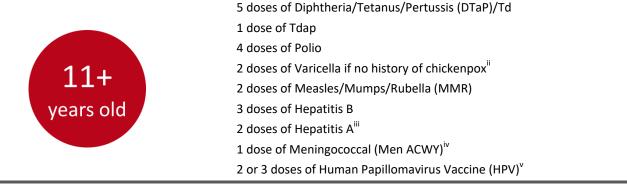
All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

## On the first day of school my student is: By the start of SY19-20, my student should have received: 4 doses of Diphtheria/Tetanus/Pertussis (DTaP) 3 doses of Polio 1 dose of Varicella if no history of chickenpox ii 1 dose of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A 3 or 4 doses depending on the brand of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)







<sup>&</sup>lt;sup>1</sup> The number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's health suite personnel or health care provider for details.

<sup>&</sup>lt;sup>II</sup> All Varicella/chickenpox histories <u>MUST</u> be verified by a health care provider and documented with month and year of disease.

iii If born on or after 01/01/05.

iv Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

<sup>&</sup>lt;sup>v</sup> Two doses if student receives first dose between ages 9 -14 (doses 6-12 months apart); 3 doses if student starts series on or after age 15.



**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 <a href="https://dchealthlink.com">https://dchealthlink.com</a>. 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:	Cł	Child First Name:				Date of Birth:							
School or Child Care Fac					Gender:	r: 🔲 Male			Female $\Box$		Non-Binary		
Home Address:				Apt: City:			State			e:	ZIP:		
Ethnicity: (check all that app	(y) Hispa	anic/Latino	Non-l	- Hispanic/Noi	n-Latino			Other			Prefer n	ot to an	swer
Race: (check all that apply)		rican Indian/ ka Native	Asian		Native Ha		n/ 🔲	Black/Af America			White		Prefer not to answer
Parent/Guardian Name:						Parer	nt/Guardi	an Phone	<b>:</b> :				
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?													
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 Hea	lth History,	Exam, and	Recomi	mendatio	ns   To	be cc	mpleted	by licen	sed he	ealth	care pro	vider.	
Date of Health Exam:	BP:	_/	NML W	eight:	☐ LE		Height:		☐ IN ☐ CM	BN	11:	BM Per	l centile:
Vision Screening: Left eye: 20/	Righ	nt eye: 20/		Correcte Uncorre				Wears gla	asses		Referred		Not tested
Hearing Screening: (check	all that apply)			Pass	☐ Fail			Not teste	ed		Jses Devid	ce 🔲	Referred
Does the child have any of the following health concerns? (check all that apply and provide details below)  Asthma													
TB Assessment   Posit	ive TST should b	e referred to P	rimary Care	Physician for	· evaluatio	n. For	questions	call T.B. C	ontrol a	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:  Skin Test Result Quantiferon Results:				<u> </u>								sitive, 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	E 6 YEARS		Develop			normal, nental Screening Date:					1 <sup>st</sup> Serum/Finger Stick Lead Level:		
Every child must have 2 lead tests by age 2	2 <sup>nd</sup> Test Date:	Result:	Normal		normal, mental Screening Date:				2 <sup>nd</sup> 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 Nan	ne:		Date of Birth:					
Immunizations	In the boxes b	oelow, provide t	he dates of imn	nunization (MM	M/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		Child had Chick Verified by:	en Pox (month &	& year):	(name	e & 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)		2	3							
Other	1	2	3	4	5	6	7			
The child is <b>behind on immunizations</b> ar	nd there is a pla	n in place to get	him/her back o	n schedule. <b>Nex</b>	t appointment i	s:				
Medical Exemption (if applicable)	al contraindicat	ion(s) to being i	mmunized at th	e time against:						
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 ☐ Var	· · ·				V					
					(date)					
Alternative Proof of Immunity (if applicable)		· / <del>-</del>	remanent	- remp	orary antii		(ddtc)			
I certify that the above child has laboratory ev	vidence of immu	unity to the follo	wing and I've at	tached a copy o	f the titer results	S.				
Diphtheria Diphtheria Der	tussis	Hib	□ не	ерВ 🔲	Polio	☐ Me	asles			
Mumps Rubella Var	ricella	Pneumococcal	□ не	ерА	Meningococca	и □ нр\	V			
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 <b>in satisfactory health</b> to participate in all school, camp, or child care activities except as										
noted on page one.										
This child is cleared for <b>competitive sports.</b> 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:										
	Provi	der Phone:								
	Provi	der Signature:			Date:					
OFFICE USE ONLY   Universal Health Certificate received by School Official and Health Suite Personnel.										
School Official Name:			ature:			Date:				
Health Suite Personnel Name:		Signature:				Date:				



## **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 co	ompleted by p	arent	:/guardia	n)						
	t Name Last Nameool or Child Care Facility Name							Middle Initial			
	Pate of Birth (MMDDYYYY)			e Zip Code							
	ichool Day- Grade care PreK3 PreK4 K 1	2 3 4	5	6 7	8	9 10	11	Adult 12 Ed.			
Part	: 2: Student's Oral Health Status (	To be comple	ted by	the dent	al prov	vider)					
incl	Does the patient have at least one tooth with aude stained pit or fissure that has no apparent be nineralized lesions (i.e. white spots).					Ye OT	es	No			
	Does the patient have at least one <b>treated cari</b> apposite, temporary restorations, or crowns as a least one treated cari		-		malgam,						
Q3	Does the patient have at least one permanent	molar tooth with a <b>r</b>	partially	or fully retair	ied sealai	nt?					
	Does the patient have untreated caries or othe tine check-up? (Early care need)	r oral health proble	ms requi	ring <b>care bef</b> o	ore his/he	er					
Q5	Does the patient have pain, abscess, or swelling	g? (Urgent care nee	ed)								
Q6	How many <b>primary teeth</b> in the patient's mout <b>or treated with fillings/crowns?</b>	h are affected by ca	ries that	are either <b>un</b>	treated	Total Numb	er				
Q7	How many <b>permanent teeth</b> in the patient's muntreated, treated with fillings/crowns, or ext	•		hat are either		Total Numb	oer				
Q8	What type of dental insurance does the patient	have? Me	dicaid	Private Insu	ırance	Other		None			
Denta	al Provider Name				Den	tal Office Star	np				
Denta	al Provider Signature										
Denta	al 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 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.

