CONFIDENTIAL FORM- SIDE ONE *Please review instruction on side two prior to completing form*

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: ☐M ☐F	Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____
Parent or Guardian Name	Telephone1: ☐Home ☐Cell ☐Work	Home Address:		Ward
Emergency Contact:	Telephone2: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)		Zipcode:
School or child care facility:	☐Medicaid ☐Private Insurance ☐None ☐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	☐ LBS ☐ KG	HT	☐ IN ☐ CM	BP: / (>3 yrs)	☐ NML ☐ ABNL	HGB / HCT (Required for Head Start)

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Dental-Oral Health	☐ None	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ None	☐ YES	☐ Referred ☐ Under Rx
Asthma	☐ None	☐ YES	☐ Referred ☐ Under Rx	Vision	☐ None	☐ YES	☐ Referred ☐ Under Rx
Development	☐ None	☐ YES	☐ Referred ☐ Under Rx	Hearing	☐ None	☐ YES	☐ Referred ☐ Under Rx
Behavioral/Emotional	☐ None	☐ YES	☐ Referred ☐ Under Rx	Nutrition	☐ None	☐ YES	☐ Referred ☐ Under Rx
Learning/Attention	☐ None	☐ YES	☐ Referred ☐ Under Rx	Neurologic	☐ None	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ 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/DTaP-1	DTP/DTaP-2	DTP/DTaP-3	DTP/DTaP-4	DTP/DTaP-5
Diphtheria-Tetanus (DT <7 yrs must have P exemption) (Td >7 yrs)	DT/Td-1	DT/Td-2	DT/Td-3	DT/Td-4	DT/Td-5
Hemophilus 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	☐ Check if hx disease Disease date _____		
Influenza (not required)	FLU-1	FLU-2	FLU-3	FLU-4	FLU-5
Pneumococcal conjugate (PCV7)	PCV7-1	PCV7-2	PCV7-3	PCV7-4	
Other					

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

TB EXPOSURE RISKS? See reverse side for instructions.	☐ HIGH→ ☐ LOW	PPD TEST DATE:	☐ NEGATIVE ☐ POSITIVE	☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ 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.	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels MUST BE Reported to DC Division of Lead Poisoning Prevention: Fax: 202-535-1398	

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

Top Copy – School Nurse **2nd Copy – School** **3rd Copy – Parent** 5/17/04