District of Columbia Immunization Requirements[1]
School Year 2018-2019

All students attending school in the District of Columbia must present proof of appropriately spaced immunizations by the first day of school.

A Child 2 years or older entering Preschool or Head Start

- **4** Diphtheria/Tetanus/Pertussis (DTaP)
- **3** Polio
- **1** Varicella (chickenpox) – if no history of disease[2]
- **1** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B) [3]
- **4** PCV (Pneumococcal)

A student 4 years old entering Pre-Kindergarten

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B) [3]
- **4** PCV (Pneumococcal)

A student 5 – 10 years old entering Kindergarten thru Fifth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A (if born on or after 01/01/05)

A student 11 years & older entering Sixth thru Twelfth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP/Td)
- **1** Tdap
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **1** Meningococcal (Men ACWY) [4]
- **2 or 3** Human Papillomavirus Vaccine (HPV) [5]

[1] At all ages and grades, the number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's school nurse or health care provider for details.

[2] All Varicella/chickenpox disease histories MUST be verified/diagnosed by a health care provider (MD, NP, PA, RN) and documentation MUST include the month and year of disease.

[3] The number of doses is determined by brand used.

[4] Quadrivalent Meningococcal (MenACWY). Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

[5] Two (2) doses if student receives first dose between 9 and 14 years of age with doses separated by 6-12 months. Three (3) doses if student starts series on or after 15 years of age.

Rev 01-18

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DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Health Requirements, School Year 2018-2019

Please turn in the following forms to the **Registrar** at your child's school when you enroll your child. DC law requires that all students be current on immunizations to attend school. DC law also requires Universal Health Certificates and Oral Health Assessments for all students enrolling in all grades.

Form	Description	Required	Notes
Universal Health Certificate	Two-page form, and two-page instructions for your medical provider	Students enrolling in all grades (PK3-12th).	Have your child's physician or nurse practitioner complete the Universal Health Certificate. The Universal Health Certificate must document immunizations, tuberculosis assessment and physical exam completed within 365 days before the start of school. Every child less than six years of age must be tested **twice** for blood lead poisoning. Testing must be completed, regardless of exposure risk, and documented on Universal Health Certificate. If your child participates in athletics, the certificate will expire 365 days from the date of the exam listed on the form. To remain eligible for athletics, an updated Universal Health Certificate must be submitted to the school when a new physical occurs. (Need health insurance? You many qualify for Medicaid or subsidized health insurance. Visit https://dchealthlink.com for more information. Need help finding a doctor? Contact your health plan's Member Services at the number printed on the back of your health insurance card.)
Immunization Documentation	Age-appropriate immunizations must be documented on the Universal Health Certificate. A one-page flier of required immunizations is included.	Students enrolling in all grades (PK3 – 12th). After 10 days of school, students who have not submitted their immunizations may be excluded from classes.	Please schedule a visit with your child's physician as soon as possible if your child's immunizations are not up to date. Some immunizations require more than one dose with return visits. If you have questions about DC's immunization requirements, please discuss them with your child's physician. You can also contact the DC Department of Health Immunization Division at 202-576-9325.
Oral Health Assessment Form	One page	Students enrolling in all grades (PK3-12th).	Have your child's dentist complete this form. (Need dental insurance? You many qualify for Medicaid or subsidized health insurance. Visit https://dchealthlink.com for more information.) (Have Medicaid, but need help finding a dental provider or making an appointment? Call 1-866-758-6807 or visit https://www.insurekidsnow.gov/coverage/find-a-dentist/index.html).
Medication Orders	There are required forms in order for the school to meet your child's medication or medical intervention needs. You can get these forms from your school's nurse or online at: http://dcps.dc.gov/service/medication-and-treatment-school.	Students who need medication or medical intervention during the school day for asthma, allergies, diabetes, seizures, or other medical conditions. If this applies to your child, please speak with your principal and nurse about your child's physical health or behavioral health condition and intervention requirements as soon as possible to make sure everyone is ready to meet your child's health needs.	Whenever possible, please administer medications at home. If your child needs to take medication or requires medical treatment during school hours, please have your child's medical provider complete the appropriate forms (Medication and Treatment Authorization Form, Asthma Action Plan and/or the Action Plan for Anaphylaxis). If students are allowed to self-administer medications for asthma, anaphylaxis, or diabetes while at school, this must be indicated on the appropriate medication action plan signed by the student's parent or guardian and physician. If you have any questions about which form is needed for your child, please speak with your school's nurse. Forms should be submitted to your school's nurse along with appropriately labeled medication (if applicable). If your child needs a dietary accommodation, your provider should also complete the Dietary Accommodations Form. To ensure that your child's health needs are met while at school, or to locate any of the forms described above, please refer to *Meeting Your Child's Medication and Treatment Needs at School,* for detailed information. This can be found at http://dcps.dc.gov/service/medication-and-treatment-school.

The school health services program provides various, free health screenings to students in specific grades. Please learn more at https://doh.dc.gov/node/113622.
If you prefer that your child not receive these screenings, please speak with your school nurse.
If you have any questions, please feel free to contact healthservices.dcps@dc.gov or 202-719-6555. You can find copies of these forms on the DCPS website.

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.

Print Name **Signature** **Date**

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 UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form replaces all physical examination forms dated before April 1, 2015. The District of Columbia Universal Health Certificate (DC UHC) is required annually for children enrolled in Child Development Facilities, Head Start, and DC public, public charter, private and parochial schools.
Exception: The DC UHC does not replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DC UHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) recommendations for child and adolescent preventive health care from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.
General Instructions: Please use a black ball point pen when completing this form.
Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which your address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. In addition, please provide the name of the insurance company and the child's identification number in the space provided. Write the name of the child's licensed health practitioner/primary care provider (doctor or nurse practitioner). If your child does not have a particular licensed health practitioner who provides care, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**
Part 2: Child's Health History, Examination & Recommendations: (To be completed by the licensed health practitioner). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination conducted by a physician, or nurse practitioner (some nurse practitioners also use the Advanced Practice Registered Nurse or APRN credential), as per the AAP recommendations, and DC Official Code § 38-602(a). The date entered here must indicate the actual date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three (3) years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is two (2) years of age or older, the BMI has to be calculated and recorded inclusive of percentile. BMI is a measurement calculated from a child's weight and height.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is **required for all children under six (6) years of age**. Also, in accordance with AAP recommendations, anemia screening is recommended for menstruating girls. Please record the blood level and indicate which test was performed by encircling HGB, HCT or both.
- **Vision and Hearing Screens:** Children should begin receiving regular objective vision screens at age three (3), and objective hearing screens at age four (4). If an objective screen cannot be completed, but there is cause for concern, provide an explanation and resolution in Part 2, Section A.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other 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 (Under Rx) for the concern. If there are NO/NONE "HEALTH CONCERNS" check the **"NO" or "NONE"** box in each health screening area.
- **SPECIAL NOTE:** "Dental Exam" – The health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No" the child should be referred to a dental home. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that children begin visiting the dentist within six (6) months of the eruption of the first tooth or by 12 months of age, and every six (6) months thereafter. For children under three (3) years of age, a licensed health practitioner may provide fluoride varnish applications if a dental home has not yet been established. Fluoride varnish applications are not required for entrance to child care or school.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE."
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE."
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark "NONE."
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Medication Plan or Licensed Practitioner's Medication Authorization Order and attach it to the DC UHC.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing: TUBERCULOSIS (TB) RISK ASSESSMENT: Perform a risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the* most recent *AAP RED BOOK, and* in accordance with DC Official Code § 38-602 (c) (1) *Examination Requirements* and *DCMR 29-325.3 (g) Public Welfare, Child Development Centers*. Current DC regulations require that all children attending a child development facility (CDF) or school undergo a comprehensive annual physical examination inclusive of a tuberculosis exposure risk assessment, which is documented on the DC UHC. A tuberculin skin test (TST) should only be conducted upon recognition of **high risk factors** for exposure to tuberculosis**.** For children who are assessed as **HIGH RISK OF EXPOSURE,** please conduct the TST and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and if the child is treated mark the "treated" box. **All positive TSTs of children younger than five (5) years of age must be reported to the DC T.B. Control Program on 202-698-4040.** If the child is assessed as having a low risk of exposure, mark **"low"** in the box**. Please note that universal tuberculin skin testing of children entering CDFs and schools is neither recommended nor required.**
• **LEAD EXPOSURE RISKS: Every child less than six years of age must be tested twice for lead, regardless of perceived exposure risk. P**lease document both the "Date" and "Result" of the most recent lead test on the DC UHC. Please indicate if "Pending." "Pending" results will be **valid for two months from the date of testing** and will not cause a child to be excluded from school-related activities or programs. The **'***Certificate of Testing for Lead Poisoning'* may also serve as test documentation and is available on the DDOE website: http://ddoe.dc.gov/publication/lead-screening-guidelines. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead and Healthy Housing Program. For detailed instructions, call 202-654-6036/202-535-2624**. **Providers may fax results to secure fax: 202-535-2607.** Please include the name, address, and phone numbers of the licensed health practitioner and parent/guardian.
Part 4: Required Licensed Health Practitioner's (physician or nurse practitioner) Certification and Signature: Providers remember to print your name and use the office/clinic stamp. Licensed health practitioner please respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation; and the child has received age-appropriate screenings (in accordance with AAP recommendations and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.
Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the licensed health practitioner to share the health information on this form with the child's school, child care facility, camp, or appropriate DC Government agency.

Forms are available online at **www.doh.dc.gov.**
Access health insurance programs at **https://dchealthlink.com**. You may contact the School Nurse through the main office at your child's school.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION
General Instructions: Please use black ball point pen when completing form
Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly the date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature, address, phone number and date. Vaccine doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day must be separated by a minimum of 28 days.

Students shall be immunized in accordance to D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 and the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Requirements – For immunization requirements for District of Columbia School and Child Care Facility attendance, consult the Department of Health Immunization Program website at https://immunization.doh.dc.gov/irswebapp/home.jsp.

Immunization requirements are subject to change.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pneumovax	PPSV or PPV23	Vaqta	Hep A
Adacel	Tdap	Fluarix	Flu (IIV)	Infanrix	DTaP	Prevnar	PCV or PCV7 or PCV13	Varivax	Varicella
Afluria	Flu (IIV)	FluLaval	Flu (IIV)	Kinrix	DTaP + IPV	ProQuad	MMR + Varicella		
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	Recombivax	Hep B		
Cervarix	HPV2	Fluvirin	Flu (IIV)	Menomune	MPSV or MPSV4	Rotarix	Rotavirus (RV1)		
Comvax	Hep B + Hib	Fluzone	Flu (IIV)	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Tripedia	DTaP		
Decavac	Td	Havrix	Hep A	Pentacel	DTaP + Hib + IPV	Twinrix	Hep A + Hep B		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviation	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenza* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name, address, phone number or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name, address, phone number or stamp date this section.

District of Columbia Oral Health (Dental Provider) Assessment Form

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.**

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 ☐Asian 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 ☐not 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 examination performed by a licensed dentist and have the DC Oral Health Assessment form completed. 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 Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.

School Health Services Program

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian/Responsible Person and Physician:

Whenever possible, your child should take their medication during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. The parent/guardian/responsible person (student or adult 18 years or older) must submit to the school nurse a completed Medication Plan, without deletions or changes. This will be kept on file in the Student's Health Record. You are responsible for obtaining the required medication information from a licensed health care provider. Medication will not be given without a completed Medication Plan.

2. A completed Medication Plan including the parent/guardian/responsible person's signed consent (part 1) and licensed health care provider's signed authorization (part 2) must be in place before the student can receive medication at school.

3. Medication Plans are effective 1 calendar year from the date signed by the licensed health care provider, unless noted otherwise.

4. The parent/guardian/responsible person shall submit a new Medication Plan to assigned Children School Services (CSS) personnel or the trained school employee whenever there is a change in the Medication Plan, to include medication strength, dose, route, time and frequency.

5. A separate Medication Plan shall be submitted for each medication to be given at school.

6. All prescription medication must be properly labeled by the pharmacist. The label must include:
    - Student's name,
    - Name and strength of medication,
    - Dose and time medication is to be given,
    - How the medication is given (or delivered) and
    - Date medication was prepared

7. Over-the-counter medication must be authorized by a licensed health care provider, must be received in the original manufacturer's container and labeled with the student's name. A pharmacy label is not required. Nurse will review these medications to ensure correct labeling, correct medication, and current date does not exceed the manufacturer's expiration.

8. The first day's dose of any new medication must be given at home.

9. Medications must be brought to school by the parent/guardian/responsible person and received by authorized personnel (a CSS employee or the trained school employee).

10. All medication kept in school will be stored in a secured area for only authorized a personnel. CSS and District of Columbia Public or Public Charter Schools personnel will not assume any responsibility for possible loss of student medication.

11. Within 1 week of the expiration of the medication or licensed health care providers Medication Plan, the unused portion of the medication must be collected by the parent/guardian/ responsible person or it will be destroyed.

12. School or CSS personnel will not assume any responsibility for unauthorized medication or medication to oneself by the student.

Government of the District of Columbia
Department of Health
Community Health Administration

MEDICATION PLAN

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN/RESPONSIBLEPERSON AUTHORIZATION AND CONSENT

Parent/Guardian/Responsible Person: Please complete and sign this section.

I hereby request and authorize CSS Personnel/Trained School Employee to administer prescribed medication as directed by the licensed health care provider to _____. This medication is a ____new (or) ____renewal prescription.
Name of Student

If new prescription, enter the date and time the first dose was given at home. Date:_____Time:_____a.m./p.m.

I hereby acknowledge that the District, and its schools, 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.

_____ _____ _____
SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PERSON RELATIONSHIP HOME PHONE

_____ _____ _____ _____
PLEASE PRINT NAME WORK/CELL PHONE E-MAILADDRESS DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR MEDICATION

Licensed Health Care Provider: Please complete and sign this plan. ___New ___Renewal ___Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

NAME AND STRENGTH OF MEDICATION:_____ DOSE/ROUTE:_____

TIME AND FREQUENCY AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF SCHOOL ADMINISTRATION:_____

Can a reaction be expected? ___YES ___NO If yes, please describe possible side effects:_____

Special instructions or emergency procedures:_____

Medication plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise, DC law 17-107 requires that medication plans be updated annually.

_____ _____
LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

_____ _____
PLEASE PRINT NAME E-mail Address

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.
.

Medication Plan authorization received by:

_____

Signature of CSS Personnel/Trained School Employee

_____

DATE

Revised 1-18-18

School Health Services Program
AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT

Dear Parent/Guardian/Responsible Person and Physician:

Students in need of medical procedures and /or treatments during the school day must meet the following requirements:

1. Parents/guardians/responsible person must present to the authorized CSS personnel a signed, completed Medical Procedure/Treatment Plan including the parent/guardian/responsible person signed consent (part 1) and licensed health care provider signed authorization for the procedure/treatment (part 2). The licensed health care provider's signed authorization and parent's signed consent will be maintained in the Student Health Record.

2. A separate Medical Procedure or Treatment Plan shall be submitted for each procedure or treatment to be given or performed at school.

3. The licensed health care provider's signed authorization must include:
   - Student's name and date of birth
   - Diagnosis, reason for procedure/treatment
   - Name of the procedure/treatment
   - Time the procedure/treatment is to be performed and/or frequency at school
   - Expected duration of treatment
   - Special instructions or emergency procedures

4. Supplies to give a medical procedure/treatment must be provided by the parent/guardian/responsible person (student or adult 18 years or older). All equipment and supplies that are required must remain in the school if possible.

5. Licensed health care provider signed authorization for medical procedures/treatments are valid for 1 year from the date signed by the provider.

6. If any adjustments (for example technique, frequency,) to the medical procedure/treatment plan are made, a new Medical Procedure/Treatment Plan is required.

7. All equipment and supplies kept in the school will be stored in a secured area accessible only to personnel giving or performing the treatment. CSS personnel and District of Columbia Public and Public Charter School personnel assume no responsibility for possible loss of or damage to equipment and supplies.

8. Within 1 week after expiration of the licensed health care providers Plan, or after any of the supplies expire, the parent/guardian/responsible person must collect the equipment and unused portion of the supplies. Expired supplies that are not collected by the parent/guardian/responsible person in that time frame will be destroyed.

9. CSS personnel and school personnel are not responsible for unauthorized procedures/treatments or those given to oneself by the student.

Government of the District of Columbia
Department of Health
Community Health Administration
MEDICAL PROCEDURE/TREATMENT PLAN

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize CSS Personnel and trained School Employees to administer the prescribed treatment as directed by the licensed Health Care Provider to _____ .

This treatment is a _____new (or) _____renewal treatment. If new treatment, enter the date and time the first treatment was given at home. Date:_____Time:_____a.m./p.m.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN PHONE RELATIONSHIP

_____ _____ _____

PLEASE PRINT NAME WORK/CELL PHONE DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR TREATMENT

Health Care Practitioner: Please complete and sign this plan. ___New ___Renewal ___Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

TREATMENT:_____

TIME &FREQUENCY AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF TREATMENT: _____

Special instructions or emergency procedures: _____

_____

Treatment plans must be updated and CSS Personnel immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

_____ _____

LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

_____ _____

PLEASE PRINT NAME EMAIL ADDRESS

_____ _____

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.

Treatment authorization received by:

_____

SIGNATURE OF CSS PERSONNEL

_____

DATE

Revised 1-18-2018