**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 Address: | | | | | Ward: |
| Emergency Contact Person: | Emergency Number: | | City/State (if other than D.C.) | | | | Zip code: | |
| 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 | **(>3 yrs)**  BP:                          □ NML  □ABNL | | | Body Mass Index**(>2 yrs)**  (BMI)\_\_\_\_\_\_\_\_\_\_\_  %\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| HGB / HCT  ***(Required for Head Start)*** | | | Vision Screening                                          □  Glasses  Right 20/\_\_\_\_     Left 20/\_\_\_\_                  □Referred | | | Hearing Screening  Pass\_\_\_\_\_\_\_\_     Fail\_\_\_\_\_\_\_\_         Referred | | | |
| **HEALTH CONCERNS:** | | | **REFERRED or TREATED** | **HEALTH CONCERNS:** | | | | **REFERRED or TREATED** | |
| Asthma | NO | YES | Referred      Under Rx | Language/Speech | | NONE | YES | Referred      Under Rx | |
| Seizure | NO | YES | Referred      Under Rx | Development/  Behavioral | | NONE | YES | Referred      Under Rx | |
| Diabetes | NO | YES | Referred      Under Rx | Other\_\_\_\_\_\_\_\_\_\_\_\_ | | NONE | YES | Referred      Under Rx | |

**A. Significant health history, conditions, communicable illness, or restriction that may affect school, child care, sports, or camp.**

**□ NONE □ YES, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.**

**□ NONE □ YES, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.**

**□ NONE □ YES, please detail (For any medications or treatment required during school hours, a Physician’s Medication Authorization Order should be submitted with this form) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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 Provider:** POSITIVE TST  should be referred to PCP for  evaluation. For questions, call T.B.  Control: 202-698-4040 |
| LEAD EXPOSURE RISKS | □YES->  □NO | LEAD TEST DATE: | RESULT: | **Health Provider:***ALL* lead levels must be reported to DC Childhood Lead  Poisoning Prevention Program: Fax: 202-481-3770 | |

|  |  |  |  |
| --- | --- | --- | --- |
| □**YES**□**NO  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  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/NP Signature | | Date |
| Address | | Phone | Fax |

**Part 4: Required Provider Certification and Signature**

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

|  |
| --- |
| **I give permission to the signing health examination/facility to share the health information on this form with my child’s school, child care, camp, or appropriate DC Government Agency.**  **Print Name Signature Date** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date of Birth:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_  Last                                                             First                                       Middle                                              Mo. /Day/ Yr.  Sex: Male  □    Female      □          School or Child Care Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Section 1: Immunization: Please fill in or attach equivalent copy with provider 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 Care Provider)  Name & Title | | | | |
| Pneumococcal Conjugate | 1 | 2 | 3 | 4 |  |  |  |
| Hepatitis A (HepA) (Born on or after 01/01/2005) | 1 | 2 |  |  |  |  |  |
| Meningococcal Vaccine | 1 |  |  |  |  |  |  |
| Human Papillomavirus (HPV) | 1 | 2 | 3 |  |  |  |  |
| Influenza (Recommended) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Rotavirus (Recommended) | 1 | 2 | 3 |  |  |  |  |
| Other |  |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_              \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Medical Provider Print Name or Stamp Date  Signature of Medical Provider                                                             Print Name or Stamp                                                       Date | | | | | | | |
| **Section 2: MEDICAL EXEMPTION. For Health Care Provider 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 Medical Provider                                                              Print Name or Stamp                                                         Date | | | | | | | |
| **Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider 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 Medical Provider                                                             Print Name or Stamp                                                        Date | | | | | | | |