# DC HEALTH Universal Health Certificate

**Use this form to** report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

## Part 1: Child Personal Information | To be completed by parent/guardian.

| | | |
|---|---|---|
| **Child Last Name:** | **Child First Name:** | **Date of Birth:** |
| **School or Child Care Facility Name:** | **Gender:** ☐ Male ☐ Female ☐ Non-Binary | |
| **Home Address:** | **Apt:** / **City:** / **State:** / **ZIP:** | |
| **Ethnicity:** *(check all that apply)* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer | | |
| **Race:** *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer | | |
| **Parent First Name:** | **Parent Last Name:** | **Parent Phone:** |
| **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?** ☐ Yes ☐ No | | |

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 Health History, Exam, and Recommendations | To be completed by licensed health care provider.

| | | | | | |
|---|---|---|---|---|---|
| **Date of Health Exam:** | **BP:** ____/____ ☐ NML ☐ ABNL | **Weight:** ☐ LB ☐ KG | **Height:** ☐ IN ☐ CM | **BMI:** | **BMI Percentile:** |

**Vision Screening:** Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

**Hearing Screening:** *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

**Does the child have any of the following health concerns?** *(check all that apply and provide details below)*

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Development
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney Failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:**_____

**Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note.** _____

_____

## TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control 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:** | **Quantiferon Test Date:** |
| | **Skin Test Results:** ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated | |
| | **Quantiferon Results:** ☐ Negative ☐ Positive ☐ Positive, 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** *Every child must have 2 lead tests by age 2* | **1st Test Date:** | **1st Result:** ☐ Normal | ☐ Abnormal, **Developmental Screening Date:** | **1st Serum/Finger Stick Lead Level:** |
| | **2nd Test Date:** | **2nd Result:** ☐ Normal | ☐ Abnormal, **Developmental Screening Date:** | **2nd Serum/Finger Stick Lead Level:** |
| **HGB/HCT Test Date:** | | **HGB/HCT Result:** | | |

## Part 3: Immunization Information | To be completed by licensed health care provider.

| Immunizations | Provide in the boxes below the dates of Immunization (MM/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 | 2 | Child had Chicken Pox (month & year): | | | | |
| 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 | | | | |

❑ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

**Medical Exemption (if applicable)**
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 ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

**Alternative Proof of Immunity (if applicable)**
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

## 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 **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ❑ No ❑ Yes

This child is cleared for **competitive sports.** Additional clearance(s) needed from: _____ ❑ N/A ❑ No ❑ Yes ❑ Yes, pending additional clearance

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:** |
|---|---|
| | **Provider Phone:** |
| | **Provider Signature:** |
| | **Date:** |

Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

## OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

| | | |
|---|---|---|
| **School Official Name:** | **Signature:** | **Date:** |
| **Health Suite Personnel Name:** | **Signature:** | **Date:** |

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

# 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 completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

| Day-care | PreK3 | PreK4 | K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Adult Ed. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Part 2: Student's Oral Health Status (To be completed by the dental provider)

| | Yes | No |
|---|---|---|
| Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots). | ☐ | ☐ |
| Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment. | ☐ | ☐ |
| Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**? | ☐ | ☐ |
| Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)** | ☐ | ☐ |
| Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)** | ☐ | ☐ |

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

**Total Number** ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

**Total Number** ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

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.

# ALLERGY ACTION PLAN

*Must be accompanied by a Medication Authorization Form

**CHILD'S NAME: _____ DOB:_____**

**ALLERGY TO:**_____

**Asthmatic:** No☐ Yes☐(high risk for severe reaction)

| **SYMPTOMS:** | **Give this Medication** | |
|---|---|---|
| ***The child has ingested a food or allergen or exposed to an allergy trigger:*** | Epinephrine | Antihistamine |
| But is **not** exhibiting or complaining of any symptoms | ☐ | ☐ |
| **Mouth:** itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny") | ☐ | ☐ |
| **Skin:** hives, itchy rash, swelling of the face or extremities | ☐ | ☐ |
| **Gut:** nausea, abdominal cramps, vomiting, diarrhea | ☐ | ☐ |
| **Throat:*** difficulty swallowing (choking feeling"), hoarseness, hacking cough | ☐ | ☐ |
| **Lung:*** shortness of breath, repetitive coughing, wheezing | ☐ | ☐ |
| **Heart:*** Weak or fast pulse, low blood pressure, fainting /"passing out", pale, blueness | ☐ | ☐ |
| **Other:** | | |

**The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.**

| **Medication:** | **Dose:** | |
|---|---|---|
| Epinephrine | | |
| Antihistamine | | |
| Other | | |

## *ACTION FOR ALLERGIC REACTION*

- If ingestion is suspected and/or symptoms are:_____,

  give_____IMMEDIATELY!
- **CALL 911**. Tell them what medications you have already administered. **DO NOT HESISTATE TO CALL 911!**
- Call Parent 1:_____phone:_____ , Parent 2_____phone:_____,

  or emergency contacts: _____ phone _____or _____ phone _____
- Call Dr._____ phone:_____

_____ _____

Parent's Signature Date

# Allergy Action Plan
## (Continued)

Must be accompanied by a Medication Authorization Form

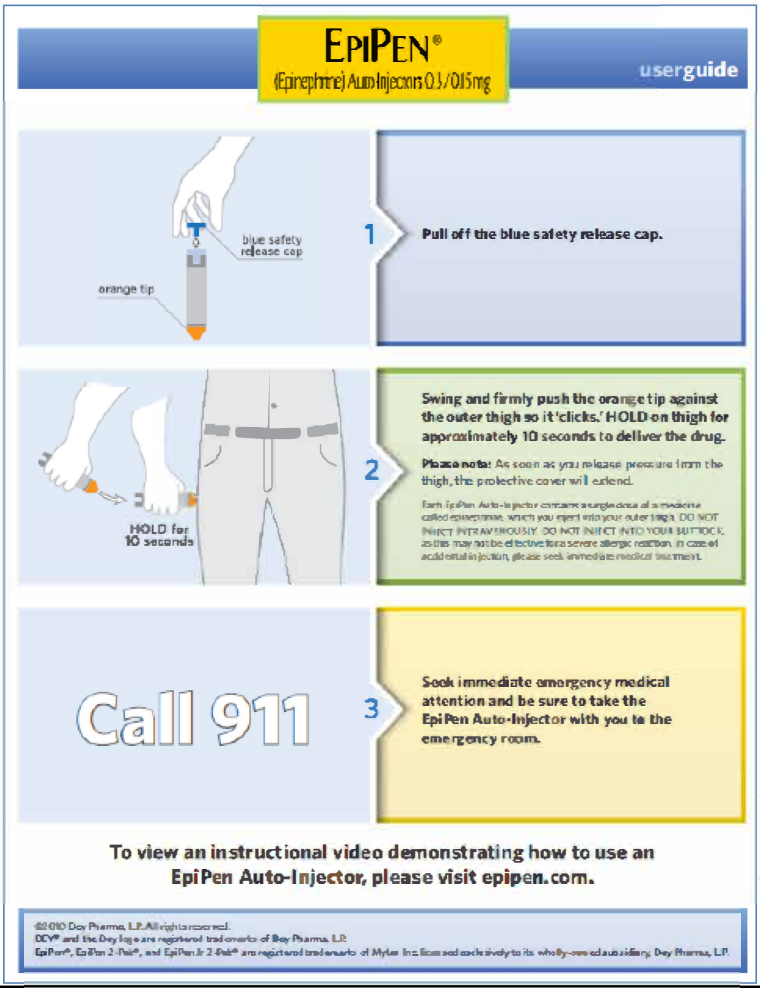
**CHILD'S NAME**: _____ **Date of Birth**: _____

**ALLERGY TO**: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

**The Child Care Facility will:**

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐




**The Parent/Guardian will:**

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# Medication Authorization Form

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1;"A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."*

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5,"A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log.*

## Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the following
*Name of Facility*

prescribed medication to my child _____ born on _____.

| Name of Medication | Time/Frequency | Dosage | Effective Dates | |
|---|---|---|---|---|
| | | | From: | |
| | | | To: | |
| | | | From: | |
| | | | To: | |

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

## Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:

| Name of Medication | Date | Time Given | Reactions | Staff Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PLEASE PLACE A COPY IN THE CHILD'S FILE.**

# CCBC Children's Center

5671 Western Avenue, NW · Washington, DC 20015 · Telephone 202-966-3299 · Fax 202-966-1717

CCBC Summer Camp includes water play every day to include (sprinklers and baby pools) during their outdoor time.

## ALLERGY AND SUNSCREEN

Child's Name: _____

Allergies: _____

Has your child ever been stung by a bee? _____

Is there a history of allergic reaction to bee sting in your family? _____

_____

---

I give CCBC summer staff permission to apply sunscreen to my child.

Child's Name _____

Parent Signature _____

Date_____

**Please make sure your child's name is on the bottle of sunscreen.**

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

**Child:** _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

---

**Relative or Guardian:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

---

**Person to be contacted in case of an emergency (other than parent/guardian):**

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

---

**Designated individual authorized to receive child at end of session:**

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

---

**Signature:** _____ **Relationship to child:** _____ **Date:** _____

---

***TO BE COMPLETED BY THE FACILITY***

**Date of Admission:** _____
**Date of Withdrawal:** _____ **Reason:** _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

***DIVISION OF EARLY LEARNING***
***Licensing and Compliance Unit***

# AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
## (Update Annually)

If my child _____, born on _____/_____/_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ❑ DC ❑MD ❑VA

Child's known Allergies or Physical Conditions: _____
_____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

**Place in child's folder/record.**

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# TRAVEL AND ACTIVITY AUTHORIZATION

❑ Special one time permission for this activity only ❑ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

**Trips in the van/automobile** (facility or parent - owned)

_____
Explain planned activity - where and when

**Field trips away from the facility**

_____
Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

❑ I will allow my child to play outside the fenced area; or

❑ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

**PLEASE KEEP A COPY IN THE CHILD'S FILE.**

# CCBC Children's Center

5671 Western Avenue, NW • Washington, DC 20015 • Telephone 202-966-3299 • Fax 202-966-1717

## DISMISSAL AUTHORIZATION

Please list all individuals who may pick up your child regularly. These are people our staff can expect to see frequently upon dismissal. Parents, child care providers, siblings over 16 years of age, relatives, neighbors or car pool participants might be listed here. **It is important to note that if your child's regular dismissal plans have changed, YOU MUST NOTIFY CCBC PERSONNEL IN WRITING OR BY PHONE EVEN IF THE INDIVUDUALS ARE LISTED HERE.** This policy is for the protection of your family.

Child's Name: _____ Class: _____

Name #1: _____ Relationship to child: _____

Address: _____

Phone Work: (  )_____-_____ Home: (  )_____-_____ Other: (  )_____-_____

Name #2: _____ Relationship to child: _____

Address: _____

Phone Work: (  )_____-_____ Home: (  )_____-_____ Other: (  )_____-_____

Name #3: _____ Relationship to child: _____

Address: _____

Phone Work: (  )_____-_____ Home: (  )_____-_____ Other: (  )_____-_____

**NOTICE:**
**If your child must be dismissed to someone other than the people listed on this form, you must inform school personnel in advance, either by phone or in writing. Each individual to whom your child is released must be at least 16 years old. CCBC staff will check identification to ensure that it matches information on this form or information you have supplied. Request to prohibit specific individuals from having access to your child must be brought to the Director's attention.**

_____
Parent's Signature and Date

# CCBC Children's Center

5671 Western Avenue, NW • Washington, DC 20015 • Telephone 202-966-3299 • Fax 202-966-1717

**PHOTOGRAPH PERMISSION FORM**

Please mark one of the following:

☐ ***I give*** permission

☐ ***I do not give*** permission

for Chevy Chase Bethesda Community Children's Center to use photographs of my child,

_____, in the Center's publications and its web site.

In consideration of the opportunity for my child to appear in CCBC

Children's Center publications and its website, I hereby release, indemnify, defend and hold harmless CCBC Children's Center from any and all claims that may arise because of such appearance.

Parent Signature _____

Date _____