

School Health Requirements, School Year 2016-2017

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 (PK3-12 th).	<p>Have your child's physician or nurse practitioner complete the Universal Health Certificate.</p> <p>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.</p> <p>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.</p> <p>(Need health insurance? You may 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.)</p>
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 – 12 th). After 10 days of school, students who have not submitted their immunizations may be excluded from classes.	<p>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.</p> <p>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 202-576-7130.</p>
Oral Health Assessment Form	One page	Students enrolling in all grades (PK3-12 th).	<p>Have your child's dentist complete this form.</p> <p>(Need dental insurance? You may qualify for Medicaid or subsidized health insurance. Visit https://dchealthlink.com for more information.)</p> <p>(Have Medicaid, but need help finding a dental provider or making an appointment? Call 1-866-758-6807 or visit http://www.insurekidsnow.gov/state/dc/district_oral.html)</p>
Medication Orders	<p>There are required forms in order for the school to meet your child's medication or medical intervention needs.</p> <p>You can get these forms from your school's nurse or online at: http://dcps.dc.gov/service/medication-and-treatment-school.</p>	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.	<p>Whenever possible, please administer medications at home.</p> <p>If your child needs to take medication or requires medical treatment during school hours, you must provide the appropriate forms, completed by your child's medical provider (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).</p> <p>If your child needs a dietary accommodation, you must submit the Dietary Accommodations form, completed by your child's medical provider.</p> <p>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 <i>Meeting Your Child's Medication and Treatment Needs at School</i> for detailed information. This can be found at http://dcps.dc.gov/service/medication-and-treatment-school.</p>



District of Columbia Immunization Requirements¹

School Year 2016 – 2017



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 disease²
- 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 disease²
- 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 disease²
- 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 disease²
- 2 Measles, Mumps & Rubella (MMR)
- 3 Hepatitis B
- 1 Meningococcal
- 3 Human Papillomavirus Vaccine (HPV)

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.



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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. Please 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	Abbreviations	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	<i>Haemophilus influenzae</i> 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 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: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity: <input type="checkbox"/> White Non-Hispanic <input type="checkbox"/> Black Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other_____
Parent or Guardian Name:	Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work.	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	City/State (if other than D.C.):		Zip code:
School or Child Care Facility:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> 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 <input type="checkbox"/> LBS <input type="checkbox"/> KG	HT <input type="checkbox"/> IN <input type="checkbox"/> CM	BP: ^(≥3yrs) <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index ^(≥2yrs) (BMI) _____ % _____
HGB / HCT <i>(Required for children under age 6)</i>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred <input type="checkbox"/> Attempted	Hearing Screening Pass _____ Fail _____	<input type="checkbox"/> Device <input type="checkbox"/> Referred <input type="checkbox"/> Attempted
HEALTH CONCERNS:	REFERRED or TREATED	HEALTH CONCERNS:	REFERRED or TREATED	
Asthma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Language/Speech <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Seizures <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Development/ Behavioral <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Other _____ <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
ANNUAL DENTIST VISIT: Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Referred <input type="checkbox"/> 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	<input type="checkbox"/> HIGH→ <input type="checkbox"/> LOW	Tuberculin Skin Test (TST) DATE:	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	If TST Positive <input type="checkbox"/> CXR NEGATIVE <input type="checkbox"/> CXR POSITIVE <input type="checkbox"/> 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: <u>ALL</u> 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 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: <input type="checkbox"/> M <input type="checkbox"/> F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Emergency Contact:		Telephone:
Race Ethnicity: <input type="checkbox"/> White Non-Hispanic <input type="checkbox"/> Black Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> 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:
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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	Y	N	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	<input type="checkbox"/> 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? <input type="checkbox"/> Prophy <input type="checkbox"/> Fluoride <input type="checkbox"/> Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment <input type="checkbox"/> is completed <input type="checkbox"/> is not completed <input type="checkbox"/> under treatment <input type="checkbox"/> refused treatment <input type="checkbox"/> not necessary. The child has ongoing <input type="checkbox"/> urgent <input type="checkbox"/> non-urgent treatment needs and is under treatment <input type="checkbox"/> by me or <input type="checkbox"/> 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 Program
AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: _____ DOB: _____

SCHOOL: _____ SOC. SEC. # _____ Grade: _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained Certified DCPS Personnel to administer prescribed medication as directed by the physician to _____

STUDENT'S NAME

I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required.

This medication is a new or renewal prescription. If new prescription, enter date and time the first dose was given at home.

Date: _____ Time: _____ A.M/P.M.

SIGNATURE OF PARENT/GUARDIAN

RELATIONSHIP

PLEASE PRINT NAME

DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this action. Original Renewal Change

NAME OF STUDENT: _____ DOB: _____

ADDRESS: _____ TEL. NO.: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSE: _____

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____

EXPECTED DURATION OF ADMINISTRATION: _____

CAN REACTION BE EXPECTED? Yes No If yes, please describe: _____

If any change, please advise in writing immediately.

PHYSICIAN'S SIGNATURE

ADDRESS

PLEASE PRINT NAME

TELEPHONE NO.

DATE

SCHOOL NURSE

DCPS TRAINED STAFF



School Health Program
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are scheduled 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. No medication will be administered without the parent's/guardian' signed consent and the physician's written medication authorization order. This will be kept on file in the Student's Health Record. The parent/guardian is responsible for obtaining the required information from the physician.
2. A separate parent/guardian consent form and physician's medication authorization order must be on file for each medication a student is to receive at school.
3. The medication must be properly labeled by the pharmacist. The label must include:
a.) Name of student's name, b.) Name of medication, c.) Date, d.) Dosage and time of administration, and e.) Directions for administration.
4. The first day's dosage of any new medication must be given at home.
5. All medications must be brought to school by the parent/guardian and given to authorized personnel.
6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.
7. All medication kept in school will be stored in a secure area accessible only to authorized administering personnel. (Such storage will be at the risk of the parent/guardian). The school nurse nor District of Columbia Public Schools (DCPS) personnel will assume any responsibility for possible loss of students' medication.
8. One week after expiration of the physician's order, the unused portion of the medication must be collected by the parent/guardian or it will be destroyed.
9. DCPS personnel nor the school nurse will assume any responsibility for non-medically prescribed medication or medication self-administered by the student.
10. Parents/guardians must let DCPS and the school nurse know in writing if a student is Lactose-intolerant.



School Health Program

AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

NAME: _____ DOB: _____

SCHOOL: _____ SSN#: _____

TEACHER: _____ GRADE: _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse (RN, LPN, Nurse's Aide, Technician) or a trained DCPS employee to perform _____

SPECIFIC MEDICAL PROCEDURE/TREATMENT

on my child _____ as prescribed by the physician below.

I have read the information on the reverse side of this form and agree to assume responsibilities as required.

SIGNATURE OF PARENT/GUARDIAN

RELATIONSHIP TO CHILD

PLEASE PRINT

DATE

PART II: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION ORDER

Physician: Please complete and sign this action.

NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

DIAGNOSIS: _____

SPECIFIC PROCEDURE/TREATMENT: _____

TO BEGIN ON: _____ AND END ON _____
DATE DATE

REASON FOR PROCEDURE/TREATMENT: _____

INSTRUCTIONS: _____

PRECAUTIONS: _____

POSSIBLE ADVERSE REACTIONS: _____

PHYSICIAN'S SIGNATURE

PLEASE PRINT

ADDRESS

PHONE

SCHOOL NURSE



School Health Program **AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT**

Dear Parent/Guardian and Physician:

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parents/guardians must present to the principal and school nurse a signed consent and physician's written authorization for the procedure/treatment. The physician's authorization and parent's consent will be maintained in the Student Health Record.
2. The parent/guardian's signed consent and physician's authorization must be in place before the student receives the specific medical procedure/treatment.
3. The physician's authorization must include: the student's name, date of birth, address, telephone number, diagnosis, name of procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.
4. The parent/guardian must meet at school with the principal, school nurse and other authorized school personnel to initiate the specific medical procedure/treatment.
5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and supplies that are required must remain in the school if possible.
6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each semester and summer school if the student continues to need the procedure/treatment.
7. If any adjustments (i.e., technique, frequency, medications) are made, a new Physician Authorization, and Parental Consent Form will be required.
8. All equipment and supplies kept in the school will be stored in a secured area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Children's National Medical Center School Health Program personnel (CNMC School Nurses) and District of Columbia Public School personnel (DCPS trained persons) assume no responsibility for possible loss of or damage to equipment and supplies.
9. One week after expiration of the physician's order, the equipment and unused portions of the supplies must be collected by the parent/guardian, or they will be discarded.
10. CSS personnel and DCPS personnel assume no responsibility for non-medically prescribed procedures/treatments or those self-administered by the student.