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* □ *Other* _____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT □ LBS □ KG	HT □ IN □ CM	BP: (>3 yrs) □ NML □ ABNL /	Body Mass Index (>2 yrs) (BMI) _____ % _____
HGB / HCT *(Required for Head Start)*	Vision Screening Right 20/____ Left 20/_____	□ Glasses □ 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

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? YES NO Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
□ **NONE** □ **YES, please detail:**

B. Significant food/medication/environmental allergies that may require *emergency medical care* **at school, child care, camp, or sports activity.**
□ **NONE** □ **YES, please detail:** _____

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)

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	

Part 4: Required Provider Certification and Signature

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

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

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