

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information Child's Last Name: Child's Fire			a middle Name.	Middle Name: Date of Bi		ardian: Please complete Part 1 clearly and completely & significant by the second of Birth: Gender: Race/Ethnicity: White Non Hispanic Description Description					Black Non Hispanic	
Cuardian Nama:		Telephone		Home Address:			Ward:					
arent or Guardian Name:		Telephone:	Cell Work	nome Au	1033.							
mergency Contact Person:	gency Contact Person: Emergency			City/State	City/State (if other than D.C.)					Zip code:		
chool or Child Care Facility:			☐ Medicaid ☐	Private Insur	ance None		Primar	y Care Provide	er (PCI	7):		
modified child date rading.			□ Other									
Part 2: Child's Healt	h Histor	ry, Examir	nation & Recomm	nendation	S	Health	Provide	r: Form mu	st be	fully cor	mpleted.	
DATE OF HEALTH EXAM:			WT □ LBS □ KG		HT DIN			(53 yrs) NML NML		Body Mass Index (BMI)		
HGB / HCT Required for Head Start)			Vision Screening Right 20/ Left 20/		☐ Glasses ☐ Referred		Hearing Screening Pass Fail □ Refer				Referred	
HEALTH CON	CERNS:		REFERRED or TREATED		HEALTH CO		ONCERNS:			REFERRED or TREATED		
sthma			☐ Referred ☐ Under Rx		Language/Speech		□ □ YES			□ Referred □ Under Rx		
Seizure	NO	YES	□ Referred □ Un		Development/ Behavioral	1	NONE	□ YES			☐ Under Rx	
Diabetes	NO	YES	☐ Referred ☐ Un	aer KX	er Rx Other		NONE	□ YES	LI F	keterred	☐ Under Rx	
NNUAL DENTIST VISIT	: (Age 3	and older):	Has the child seen	a Dentist/D	ental Provider wi	thin the la	ast year?	□ YES	□ NC	Ref	ferred	
a. Significant health I NONE □ YES, plea B. Significant food/m ports activity. □ NONE □ YES, plea	edicationse deta	il: on/enviror il:	nmental allergies	that may				care at sc	hool	, child c	are, camp, c	
NONE ☐ YES, plea S. Significant food/m ports activity. NONE ☐ YES, plea S. Long-term medica NONE ☐ YES, plea	edications, on see deta	on/enviror iil: over-the-co	nmental allergies ounter-drugs (OT	that may	cial care requi	irement	s.					
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NONE ☐ YES, plea S. Significant food/m ports activity. NONE ☐ YES, plea C. Long-term medica NONE ☐ YES, plea hould be submitted wi	edications de deta	on/enviror iil: over-the-co iii (For any orm) Exposure	ounter-drugs (OT medications or tre	that may	cial care requi luired during sc :	If TST F	Positive	ysician's M	H si e c	ealth Provinculd be refevaluation. Frooutrol: 202-	der: POSITIVE TS arred to PCP for or questions, call T.I.	
NONE ☐ YES, plea S. Significant food/m ports activity. NONE ☐ YES, plea C. Long-term medica NONE ☐ YES, plea hould be submitted with Part 3: Tuberculosis TB RISK ASSESSMENT LEAD EXPOSURE RISK	edications de deta	on/enviror iil: ever-the-co iii (For any orm) Exposure HIGH-	nmental allergies ounter-drugs (OT medications or tre	that may	cial care requi juired during sc : : : NEGATIVE	If TST F	Positive	ysician's M	H si e c	ealth Provinculd be refevaluation. Frooutrol: 202-	thorization Ordania der: POSITIVE TS erred to PCP for questions, call T. 698-40405	
NONE YES, plea S. Significant food/m ports activity. NONE YES, plea S. Long-term medica NONE YES, plea Hould be submitted with Part 3: Tuberculosis TB RISK ASSESSMENT LEAD EXPOSURE RISI Part 4: Required Provi	edications detailed and the sed detailed and the se	il: on/enviror il: over-the-co il (For any orm) Exposure DHIGH- DLOW STEATON AND Ification and as been application is cleared	Dunter-drugs (OT medications or tree Risk Assessment Tuberculin Ski (TST) DATE: LEAD TEST D d Signature propriately examparticipate in all for competitive	& Testing n Test ATE: nined & h school, cosports.	cial care requipulated during sc : : : : : : : : : : : : :	If TST F	Positive egative strive provider: At g Prevention	ysician's M	Hedical Hedica	ealth Providud to End of the Control 202- east	der: POSITIVE TS erred to PCP for or questions, call T. 698-4040 DC Childhood Lead	
NONE □ YES, plea S. Significant food/m ports activity. NONE □ YES, plea C. Long-term medica NONE □ YES, plea Hould be submitted with Part 3: Tuberculosis TB RISK ASSESSMENT LEAD EXPOSURE RISI Part 4: Required Provi	edications detailed and the sed detailed and the se	il: on/enviror il: over-the-co il (For any orm) Exposure DHIGH- DLOW STEATON AND Ification and as been application is cleared	Dunter-drugs (OT medications or tree Risk Assessment Tuberculin Ski (TST) DATE: LEAD TEST D d Signature propriately examparticipate in all for competitive	& Testing n Test ATE: nined & h school, cosports.	cial care requipulated during sc : : : : : : : : : : : : :	If TST F	Positive egative strive provider: At g Prevention	ysician's M	Hedical Hedica	ealth Providud to End of the Control 202- east	der: POSITIVE TS erred to PCP for or questions, call T. 698-4040 DC Childhood Lead is in	
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Signature

Date

Print Name

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name:	<u>/</u>	ARIESTA			Date of Birth:		/	
Last Sex: Male Female School or Child Ca		irst	Mi	iddle		Mo. /Day/ Y	ſr.	
Section 1: Immunization: Please fill in or attach equivale	ent copy with pr	rovider signatu	ure and date.	3.00		to terror and the first	Win	
IMMUNIZATIONS	F	RECORD COM	PLETE DATES	(month, day,	year) OF VACCIN	IE DOSES GIV	EN	
Diphtheria,Tetanus, Pertussis (DTP,DTaP)		,				All a second	PACE TO SERVICE	
DT (<7 yrs.)/ Td (>7 yrs.)				name in		March San		
Tdap Booster		3 4 1. 3				阿拉斯斯	· 特定	
Haemophilus influenza Type b (Hib)		2	3	1		100 page 1		
Hepatitis B (HepB)	A SPECIAL PROPERTY OF THE PROP	2	3	•				
Polio (IPV, OPV)		2	3	4		· 特别的		
Measles, Mumps, Rubella (MMR)	issair 1	2		And the second	The second second	a leverage		
Measles	Constant of	2			Section of the sectio	THE SECTION		
Mumps	HTJMSH	2	SAME A		约 斯特·斯	100 to 10	The Control of the Co	
Rubella		2		500000	Contraction of the contraction o	garles and		
Varicella	Chicken Pox C			ox Disease History: Yes When: Month				
se sparit unispital position			Verified by:	Name & Ti	27		th Care Provider)	
Pneumococcal Conjugate	an zemila	2	3	Tarrens and a			and the	
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2			i de la companya de l		Control of the state of the sta	
Meningococcal Vaccine	1			公司		gle AP	Star Star	
Human Papillomavirus (HPV)	1	2	3			Zinaca Postilia Kongrafia	建洲	
Influenza (Recommended)	ı	2	3	The state of the s	5	6	T CARLON OF THE PARTY OF THE PA	
Rotavirus (Recommended)	n miliopy 1	Z Missey	3 ₍₀ (0)(0) e	AN OF TOWNS				
Other				Salah Berandaran	A FIRST PROPERTY OF	a surface service	· 医原性脑膜炎	
Out.	1					建筑水桥内 。		
Signature of Medical Provider	Print Nam	ne or Stamp			Date			
Section 2: MEDICAL EXEMPTION. For Health Care Provide					A process of the			
I certify that the above student has a valid medical contraindical	430.45	Charles of Section 2	" against (c)	and all that an	Control Physics	All Districts	personal residence	
Diphtheria: () Tetanus: () Pertussis: () Hib: () HepB:								
HepA: () Meningococcal: () HPV: ()	,	/ IVICasios	Mullips	Rubelia	/ancella File	iumococcai	ک	
Reason:	molveri yan it wa mana muda	in disert a						
This is a permanent condition () or temporary condition (shaqq avii	la page to	borging of si		_	
Signature of Medical Provider	Print Na	me or Stamp		38				
Section 3: Alternative Proof of Immunity. To be completed		(2.5)	. III Official		Date			
certify that the student named above has laboratory evidence			***************************************		Carlot Harris			
Diphtheria: () Tetanus: () Pertussis: () Hib: () HepB:								
HepA: () Meningococcal: () HPV: ()	,	Measies.	Murrips	Rubella	ancella File	umococcai	ک	
A STATE OF								
Signature of Medical Provider	Print Nam	ne or Stamp			Date ,			
	er a de la berrar de la company							