

DC HEALTH Certificado Universal de Salud

Use este formulario para informar sobre la salud física de su hijo a su escuela/centro de cuidado infantil. Esto es requerido por la Sección 38-602 del Código Oficial del Distrito de Columbia. Pida a un profesional médico autorizado que complete las partes 2 a 4. Acceda a los programas de seguro de salud en <https://dchealthlink.com>. Puede comunicarse con el personal de la sala de salud a través de la oficina principal de la escuela de su hijo.

Parte 1: Información personal del niño | A ser completada por el padre/tutor.

Apellido del niño:		Nombre del niño:			Fecha de nacimiento:	
Nombre de la escuela o centro de cuidado infantil:				Sexo: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino <input type="checkbox"/> Ninguno de los dos anteriores		
Dirección residencial:		Apartamento:	Ciudad:	Estado:	CÓDIGO POSTAL:	
Etnia (marque todo lo que corresponda) <input type="checkbox"/> Hispano/latino <input type="checkbox"/> No hispano/no latino <input type="checkbox"/> Otro <input type="checkbox"/> Prefiere no responder						
Raza: (marque todo lo que corresponda) <input type="checkbox"/> Indio americano/nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Hawaiano nativo / Americano de otra Isla del Pacífico <input type="checkbox"/> Negro/africano <input type="checkbox"/> Blanco <input type="checkbox"/> Prefiere no responder						
Nombre del padre/tutor:				Teléfono del padre/tutor:		
Nombre de contacto en caso de emergencia:				Teléfono de contacto en caso de emergencia:		
Tipo de seguro: <input type="checkbox"/> Medicaid <input type="checkbox"/> Privado <input type="checkbox"/> Ninguno			Nombre/N.º de identificación del seguro:			
¿Ha visto el niño a un dentista/proveedor de servicios odontológicos en el último año?						<input type="checkbox"/> Sí <input type="checkbox"/> No
<p>Autorizo al examinador médico/centro de salud que firma para compartir la información médica en este formulario con la escuela, el centro de cuidado infantil, el campamento de mi hijo o la agencia gubernamental del Distrito de Columbia correspondiente. Asimismo, por el presente, reconozco y acepto que el Distrito, la escuela, sus empleados y agentes tendrán inmunidad frente a toda responsabilidad civil por actos u omisiones de acuerdo con la Ley 17-107 del Distrito de Columbia, excepto por actos criminales, actos ilícitos intencionales, negligencia grave o mala conducta intencional. Entiendo que este formulario debe completarse y devolverse a la escuela de mi hijo todos los años.</p>						
Firma del padre/tutor: _____				Fecha: _____		

Parte 2: Child's Health History, Exam and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	BP: <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight: <input type="checkbox"/> LB <input type="checkbox"/> KG	Height: <input type="checkbox"/> IN <input type="checkbox"/> CM	BMI:	BMI Percentil:
Vision Screening Left eye: 20/____ Right eye: 20/____	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Wears Glasses <input type="checkbox"/> Referred <input type="checkbox"/> Not tested			
Hearing Screening: (check all that apply)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested	<input type="checkbox"/> Uses device	<input type="checkbox"/> Referred		
Does the child have any of the following health concerns? (Check all that apply and provide details below)					
<input type="checkbox"/> Asthma	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Sickle Cell			
<input type="checkbox"/> Autism	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. Details Provided below			
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements Details Provided below			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Language/Speech	<input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions Details provided below.			
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Developmental	<input type="checkbox"/> Scolliosis				
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures				
Provided details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment 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 of TB?	Skin Test Date:	Quantiferon Test Date:
<input type="checkbox"/> High → complete skin test and/or Quantiferon test	Skin Test Results <input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative <input type="checkbox"/> Positive, CXR Positive	
<input type="checkbox"/> Low	<input type="checkbox"/> Positive, Treated	
	Quantiferon Results <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Positive, Treated	

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to the 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 elad tests by age 2	1st Test Date:	1st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1st Serum/Finger Stick Lead Level:
	2nd Test Date:	2nd Result : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, DEvelopmental Screening Date:	2nd Serum/Finger Stick Lead Level

HGB/HCT Test Date:	HGB/HCT Result:
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Parte 3: Immunization Information | To be completed by licensed health care provider.

Child's Last Name:					Child's First Name:			Date of Birth:		
Immunizations	In the boxes below, provide 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): Verified by: _____ (name & title)							
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							
Other	1	2	3	4	5	6	7			

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 contraindication (s) to being immunized at the time against

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

¿Is this medical contraindication permanent or temporary? Permanent Temporal until: _____ (date)

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

Parte 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

Este niño está autorizado para realizar **competitive sports**. N/C No YEs Yes, pending additional clearance form: _____

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:	

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

School Office Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date: