DC HEALTH አለም አቀፍ የጤና የምስክር ወረቀት

የልጅዎን አካላዊ ጤንነት ለትምህርት ቤታቸው/ለልጆች እንክብካቤ ተቋም ለማሳወቅ ይህንን ቅጽ ይጠቀሙ። ይህ በዲሲ ባለስልጣን ኮድ §38-602 ይፈለጋል። ክፍል 2 - 4 ፈቃድ ያለው የሕክምና ባለሙያ ይሙላ። የጤና መድን መርሀ ግብሮችን በ https://dchealthlink.com ያግኙ። የጤና ጥበቃ ቢሮ ሰራተኛ በልጅዎ ትምህርት ቤት ዋና ጽሕፈት ቤት በኩል ማግኘት ይችላሉ።

ክፍል 1: የልጅ ግላዊ መረጃ በወላጅ / አሳዳጊ መሞላት አለበት።

የልጅ አባት ሥም:	**Cየልጅ ሥም:**	**የትውልድ ጊዜ:**
የትምህርት ቤት ወይም የልጅ ተንከባካቢ ድርጅት ስም:	**ፆታ:** ☐ ወንድ ☐ ሴት ☐ አይነተኛ እሴት	
የቤት አድራሻ:	**አፓርት:** **ከተማ:** **ግዛት:** **ዚፕ:**	
ዘር: *(የሚመለከታቸው ሁሉ ላይ ምልክት ያድርጉ)* ☐ ሂስፓኒሽ/ላቲኖ ☐ ስፓኒሽ ያልሆኑ እና ላቲኖ ያልሆኑ ☐ ሌላ ☐ መልስ ላለመስጠት በመምረጥ		
ዘር: *(የሚመለከታቸው ሁሉ ላይ ምልክት ያድርጉ)* ☐ የአሜሪካ, ሕንድ / የአላስካ ተወላጅ ☐ እስያ ☐ የሃዋይያዊ ተወላጅ / የፓስፊክ ደሴተኛ አሜሪካዊ ☐ ጥቁር/አፍሪካዊ ☐ ነጭ ☐ መልስ ላለመስጠት በመምረጥ		
Parየወላጅ / አሳዳጊ ሥም:	**የወላጅ / አሳዳጊ ስልክ:**	
የአደጋ ጊዜ ተጠሪ ሥም:	**የአደጋ ጊዜ ተጠሪ ስልክ:**	
የመድን ዓይነት: ☐ Medicaid ☐ የግል ☐ ምንም	**የመድን ስም/መታወቂያ ቁጥር:**	
ልጁ ባለፈው አመት ውስጥ በጥርስ ህኪም/በጥርስ ህክምና ባለሞያ ታይቷል? ☐ አዎን ☐ አይ		

በዚህ ቅጽ ላይ የሚገኘውን የጤና መረጃ ከልጁ ትምህርት ቤት፣ ሕጻናት ጥበቃ፣ ካምፕ ወይም ተገቢነት ላለው የዲሲ የመንግስት ወኪል ድርጅት ጋር እንዲያጋራ ፈራሚ የጤና መርማሪን/ተቋምን ፈቃድ እሰጣለሁ። በተጨማሪም በወንጀል ድርጊቶች፣ ሆን ተብሎ የሚፈጸመው መጥፎ ድርጊት፣ ከፍተኛ ቸልተኝነት ወይንም ሆን ተብሎ የተፈፀመ መጥፎ ተግባር ካልሆነ በስተቀር አውራጃው፣ ትምህርት ቤቱ፣ ሰራተኞቹና ተወካዮችበዲሲ ሕግ 17-107 መሠረት ለዲሲ ፕሊን ተጠያቂነት እና ግዴታዎች ከሲቪል ተጠያቂነት ነጻ መሆን እንዳለባቸው እቀበላለሁ። ይህ ቅጽ መሞላት እና በየዓመቱ ለልጁ ትምህርት ቤት መመለስ እንዳለበት ተረድቼያለሁ።

የወላጅ / አሳዳጊ ፊርማ:_____ **ቀን:**_____

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
- ☐ Developmental
- ☐ 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, orrestrictions. *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.

Child Last Name:	Child 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 medical 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 ☐ Temporary 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

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.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

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 Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date: