



District of Columbia Immunization Requirements¹

School Year 2017 – 2018



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 (Men ACWY)⁴
- 2 or 3 Human Papillomavirus Vaccine (HPV)⁵

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.

⁴ Quadrivalent Meningococcal (MenACWY). Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

⁵ Two (2) doses if student receives first dose between 9 and 14 years of age with doses separated by 6-12 months. Three (3) doses if student starts series on or after 15 years of age.



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	Prenar	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	RotaTaq	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 influenza</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 (BMI) _____ % _____ (≥2 yrs)
HGB / HCT (Required for children under age 6)	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 UNIVERSAL HEALTH CERTIFICATE

Student Last Name: _____

Student First Name: _____

DOB: _____

Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's signature and date.							
IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
	1	2	3	4	5		
Diphtheria, Tetanus, Pertussis (DTP, DTaP)							
DT (<7 yrs.)/ Td (>7 yrs.)							
Tdap Booster							
Haemophilus influenza Type b (Hib)							
Hepatitis B (HepB)							
Polio (IPV, OPV)							
Measles, Mumps, Rubella (MMR)							
Measles							
Mumps							
Rubella							
Varicella							
Chicken Pox Disease History: Yes <input type="checkbox"/> When: Month _____ Year _____ Verified by: _____ (Health Practitioner) <div style="text-align: center;">Name & Title</div>							
Pneumococcal Conjugate							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
Meningococcal Vaccine							
Human Papillomavirus (HPV)							
Influenza (Recommended)							
Rotavirus (Recommended)							
Other							
Signature of Licensed Health Practitioner _____		Print Name or Stamp _____			Date _____		
Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner Use Only.							
I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply) Diphtheria: () Tetanus: () Pertussis: () Hib: () HepB: () Polio: () Measles: () Mumps: () Rubella: () Varicella: () Pneumococcal: () HepA: () Meningococcal: () HPV: () Reason: _____ This is a permanent condition () or temporary condition () until ____/____/____.							
Signature of Licensed Health Practitioner _____		Print Name or Stamp _____			Date _____		
Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner or Health Official.							
I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results) Diphtheria: () Tetanus: () Pertussis: () Hib: () HepB: () Polio: () Measles: () Mumps: () Rubella: () Varicella: () Pneumococcal: () HepA: () Meningococcal: () HPV: ()							
Signature of Licensed Health Practitioner _____		Print Name or Stamp _____			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:

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	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"/> Prophylaxis <input type="checkbox"/> Fluoride <input type="checkbox"/> Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐ is completed ☐ is not completed ☐ under treatment ☐ refused treatment ☐ not necessary.
The child has ongoing ☐ urgent ☐ non-urgent treatment needs and is under treatment ☐ by me or ☐ 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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health



Human Papillomavirus (HPV) Annual Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM

Section 1: Enter student information

Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
 - a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
 - b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
 - c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress this issue at any time and complete the required vaccinations.

Signature of Parent/Guardian or Student if >18 years

Date

Print Name of Parent/Guardian or Student if >18 years

Updated January 2015 (SY 2015-2016)

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose:** Now
- **2nd Dose:** two months after Dose 1
- **3rd Dose:** six months after Dose 1

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-7130 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).