

**Oral Health Assessment Form**

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

**Instructions**

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

**Part 1: Student Information (To be completed by parent/guardian)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

School or Child Care Facility Name \_\_\_\_\_

Date of Birth (MMDDYYYY)

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Home Zip Code

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School Grade	Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2: Student's Oral Health Status (To be completed by the dental provider)**

	Yes	No		
Q1 Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	<input type="checkbox"/>	<input type="checkbox"/>		
Q2 Does the patient have at least one treated carious tooth? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need)	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have pain, abscess, or swelling? (Urgent care need)	<input type="checkbox"/>	<input type="checkbox"/>		
Q6 How many primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns?	Total Number		<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Q7 How many permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries?	Total Number		<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Q8 What type of dental insurance does the patient have?	Medicaid	Private Insurance	Other	None
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Provider Name _____	Dental Office Stamp
Dental Provider Signature _____	
Dental Examination Date _____	

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

# DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at <https://dchealthlink.com>. You may contact the Health Suite Personnel through the main office at your child's school.

## Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:		Child First Name:		Date of Birth:	
School or Child Care Facility Name:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		
Home Address:		Apt:	City:	State:	ZIP:
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer					
Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer					
Parent/Guardian Name:			Parent/Guardian Phone:		
Emergency Contact Name:			Emergency Contact Phone:		
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None		Insurance Name/ID #:			

Has the child seen a dentist/dental provider within the last year?  Yes  No

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. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Part 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 Percentile: _____
Vision Screening: Left eye: 20/____ Right eye: 20/____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected		<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"/> Developmental  | <input type="checkbox"/> Scoliosis         |   |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Seizures          | <input type="checkbox"/> 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? <input type="checkbox"/> High → complete skin test and/or Quantiferon test <input type="checkbox"/> Low	Skin Test Date:		Quantiferon Test Date:	
	Skin Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative <input type="checkbox"/> Positive, CXR Positive <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 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	1 <sup>st</sup> Test Date:	1 <sup>st</sup> Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1 <sup>st</sup> Serum/Finger Stick Lead Level:
	2 <sup>nd</sup> Test Date:	2 <sup>nd</sup> Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	2 <sup>nd</sup> Serum/Finger Stick Lead Level:

HGB/HCT Test Date:	HGB/HCT Result:
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**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 influenzae 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:



## Medication Authorization Form

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1: "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."*

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5, "A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log."*

### **Part I: To be completed by the parent/guardian and child's physician:**

I do hereby give permission to \_\_\_\_\_ to administer the following  
*Name of Facility*

prescribed medication to my child \_\_\_\_\_ born on \_\_\_\_\_.

Name of Medication	Time/Frequency	Dosage	Effective Dates	
			From:	To:
			From:	
			To:	
			From:	
			To:	

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### **Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:**

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE.



# EDUCATION

## REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

**Child:** \_\_\_\_\_ Sex:  Male  Female  
Last First M.I.  
Date of Birth: \_\_\_\_\_ Home #: \_\_\_\_\_ Language Spoken At Home \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Parent:** \_\_\_\_\_ Home # \_\_\_\_\_  
Last First M.I. Business # \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP  
Business Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Parent:** \_\_\_\_\_ Home # \_\_\_\_\_  
Last First M.I. Business # \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP  
Business Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Relative or Guardian:** \_\_\_\_\_ Home # \_\_\_\_\_  
Last First M.I. Business # \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP  
Business Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Person to be contacted in case of an emergency (other than parent/guardian):**  
\_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Last First M.I.  
Address: \_\_\_\_\_  
Number Street Apt. # State ZIP Phone #

**Designated individual authorized to receive child at end of session:**  
\_\_\_\_\_  
Last First M.I.  
\_\_\_\_\_  
Last First M.I.  
\_\_\_\_\_  
Last First M.I.

**Signature:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*TO BE COMPLETED BY THE FACILITY*

**Date of Admission:** \_\_\_\_\_  
**Date of Withdrawal:** \_\_\_\_\_ **Reason:** \_\_\_\_\_



## TRAVEL AND ACTIVITY AUTHORIZATION

- Special one time permission for this activity only       Blanket permission for all given activities

I, \_\_\_\_\_ parent/guardian of  
Name of Parent/Guardian  
\_\_\_\_\_ give my permission  
Name of Child  
\_\_\_\_\_ for my child to  
participate in the following activities:

### **Trips in the van/automobile (facility or parent - owned)**

\_\_\_\_\_  
Explain planned activity - where and when

### **Field trips away from the facility**

\_\_\_\_\_  
Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devices and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

- I will allow my child to play outside the fenced area; or  
 I will not allow my child to play outside the fenced area.

This authorization is valid from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

**PLEASE KEEP A COPY IN THE CHILD'S FILE.**