DC HEALTH School Immunization Requirements Guide

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Please complete and return your student's school health forms including the Universal Health Certificate and Oral Health Assessment Form.
ALL STUDENTS SHOULD RECEIVE AN ANNUAL FLU VACCINE

My student should receive these vaccine doses upon school enrollment*

2-3 years old

Preschool to Head Start

The following vaccines are typically received before the age of 2:

4 doses of Diphtheria/Tetanus/Pertussis (DTaP)
3 doses of Polio
1 dose Varicella if no history of chickenpox
1 dose of Measles/Mumps/Rubella (MMR)
3 doses of Hepatitis B
2 doses of Hepatitis A
3 or 4 doses depending on the brand of Hib (Haemophilus Influenza Type B)
4 doses of PCV (Pneumococcal)

4-6 years old

Kindergarten to 1st Grade

Additional doses needed after receiving the vaccines listed above:

1 dose of Diphtheria/Tetanus/Pertussis (DTaP)
1 dose of Polio
1 dose of Varicella if no history of chickenpox
1 dose of Measles/Mumps/Rubella (MMR)

7-10 years old

2nd Grade to 5th Grade

Consult your doctor and make sure your student received all the vaccines listed above!

11+ years old

6th Grade to High School

Additional vaccines needed after receiving all vaccine doses listed above:

1 dose of Tdap
2 doses of Meningococcal (Men ACWY)
2 or 3 doses of Human Papillomavirus Vaccine (HPV)

*The spacing and number of doses required may vary. Please contact your child's health care provider. For additional information, contact DC Health's Immunization Program at (202) 576-7130.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Annual Human Papillomavirus (HPV) 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

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).

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:** ☐ Male ☐ Female ☐ Non-Binary	

Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**

Ethnicity: *(check all that apply)* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer

Race: *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer

Parent/Guardian Name:	**Parent/Guardian Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**

Insurance Type: ☐ Medicaid ☐ Private ☐ 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:** ____ /_____	☐ 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, or restrictions. *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: