SCHOOL HEALTH SERVICES PROGRAM ACKNOWLEDGEMENT

The DC Health School Health Services Program provides health care services to students throughout the school day as well as administers hearing and vision screenings, manages student health records and tracks student health trends in the District of Columbia. The School Health Services Program also offers telehealth which requires a parental/guardian consent form to be submitted in order for a student to participate.

Your student will receive a hearing and/or vision screening if they have not received one in the previous calendar year, as documented in their submitted universal health certificate. Your student's health data may be transferred electronically between authorized District agencies, their agents and your student's healthcare providers. Student health information will always be stored and transferred in accordance with District and federal laws and regulations including, but not limited to, the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act and D.C. Law 18-273, the Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Official Code § 7-241 et seq.)

If you would like to opt-out of your student receiving a hearing and/or vision screening or electronic health data transfers please submit in writing your request to your student's registrar, school health suite staff or submit it electronically via the School Health Services Program Information and Request Online Portal.

If you would like to consent for your student to participate in the School Health Services Telehealth Program, please submit the below completed form to your student's registrar or school health suite staff to consent for telehealth services.

2201 Shannon Place SE, 5th Fl | Washington, DC 20020 | P 202-442-5925 | F 202-442-4947 | dchealth.dc.gov

SCHOOL HEALTH SERVICES TELEHEALTH CONSENT

Please submit the completed document to your student's school registrar or health suite staff. The School Health Services Telehealth Program allows students to be seen remotely at their school by a medical care provider. By signing below, I understand, acknowledge and agree that:

- My student may participate in appointments conducted by video (video conferencing) or phone call (teleconferencing) with healthcare providers such as behavioral health providers who may be at an off-school location. The healthcare provider may determine that an in- person follow-up visit or that urgent care or emergency services is required.
- In addition to my student's healthcare team and provider, individuals who operate the video equipment and who are trained to maintain the confidentiality of all information obtained may also be present. The student has the right to request that: (1) specific details of their medical history/physical examination be omitted; (2) non-medical personnel leave the examination room; or (3) the visit be terminated at any time.
- I have the option to refuse a telehealth appointment for my student.
- I authorize the School Health Services Telehealth Program to share my student's educational records and health information with a telehealth provider for the purpose of providing care to my student.
- I authorize the provider or its healthcare personnel to release any and all information to my student's health insurance plan or any other agent that may be responsible for paying medical bills associated with the visit. I further authorize the School Health Services Telehealth Program to release specific medical information to school officials and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my student's health and safety.
- My insurance may be billed for Telehealth services. I understand I am responsible for providing insurance information and am responsible for any additional copay or charge resulting from this service. Enrollees in any DC Medicaid Managed Care Organization will not receive a bill for any of the services provided through telehealth. All charges associated with this program are at the discretion of the insurance company. Any copay that is required for primary care visits could apply for this service. I understand that any monies or benefits for providing telehealth will be assigned and transferred to the provider, including benefits/monies from my health plan, Medicaid, or other third parties who are financially responsible for my student's medical care. I authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes.
- If I am not satisfied with the services rendered at any time, I may file a complaint with the Ombudsman team via phone: (202) 724-7491 or via email: healthcareombudsman@dc.gov. Complaints should also be submitted via the School Health Services Program portal at: https://dchealth.force.com/studenthealthservices/s/.
- This consent will be valid for the duration of the student's enrollment in the school. I also understand that I have the right to withdraw my consent at any time by giving the health suite staff a signed and dated letter withdrawing my consent.

Student's Personal Information | Completed by parent/guardian/student eighteen (18) years of age or older				
Student Last Name:		**Student First Name:**		**Date of Birth:**
School or Child Care Facility Name:				
Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**
Ethnic Designation: *(check all that apply)* ☐ Hispanic/Latino ☐ Other ☐ Non-Hispanic/Latino ☐ Prefer not to answer				
Race: *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Prefer not to answer				

Parent/Guardian Information			
Parent/Guardian Name 1:		**Parent/Guardian Name 2:**	
Phone:	**Email:**	**Phone:**	**Email:**
Relationship to Student:		**Relationship to Student:**	
Parent/Guardian Phone:		**Parent/Guardian Phone:**	
Emergency Contact Name, Relationship to Student:		**Emergency Contact Phone:**	

Insurance Information	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:** **Insurance Plan:**
If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance? ☐ Yes ☐ No	
Primary Care Provider Name:	
Primary Care Provider Organization & Address:	
Primary Care Provider Phone:	

Student Name (printed)_____ **Parent/Guardian Name (printed)**_____

Parent/Guardian Signature/Student if age is 18 or older_____ **Date** _____

SCHOOL HEALTH SERVICES PROGRAM POLICIES

The below School Health Services Program Policies are provided for your awareness.

- To participate in the in the electronic transfer of my student's data for the SHSP, I must provide consent to my student's medical care provider to electronically send my student's health information including, but not limited to the information in the universal health certificate, to my student's school. Information regarding care provided to my student in my student's school may be shared with other District agencies for the purpose of coordinating my student's care and for District-wide data collection, for example to monitor asthma or other health trends in the District.
- A student that is eighteen (18) years of age or older, or an emancipated minor, as defined by D.C. Official Code § 7-1231.02 (10), may complete this form for themselves and legally consent to any school health services.
- In accordance with the Minor's Health Consent Regulation (22-B DCMR § 600.7) a minor may legally consent for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered.
- The consents and acknowledgements contained herein will be valid for the duration of the student's enrollment. I may withdraw consent at any time by providing a signed and dated letter to the student's school.
- As provided for in D.C. Official Code § 38-651.11, the District, the school, its employees and agents (including school nursing staff) or the practicing physician, physician assistant or advanced practice nurse, who has issued a standing order shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code § 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

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Universal Health Certificate

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MURIEL BOWSER, MAYOR

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 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:		**Student Grade Level:**	**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:** ☐ LBS ☐ KG	**Height:** ☐ IN ☐ CM	**BMI:**	**BMI Percentile:**
Vision Screening Acuity Level: For Children 3–6 years of age, only a (Pass/Fail) will be required. Those age 6 years and over will require vision acuity levels for this section.					
Vision Screening: Left eye: 20/_____ L: ☐ Pass ☐ Fail	Right Eye: 20/_____ R: ☐ Pass ☐ Fail	☐ Corrected ☐ Uncorrected	☐ Wears glasses	☐ Referred	☐ Not tested
Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not Tested ☐ Uses Device ☐ Referred					

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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 TB tests should be referred to Primary Care Provider for evaluation. For questions call DC Health TB Control at 202-698-4040. Visit dchealth.dc.gov/page/tuberculosis-basics for more information on Tuberculosis.

What is the child's risk level for TB?	**Skin Test Date:**	**IGRA Blood Test Date:**
☐ High > *complete skin test and/or IGRA blood test* ☐ Low	**Skin Test Results:** ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated	**IGRA 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) 481-3837 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:**
	3rd Test Date:	**3rd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**3rd Serum/Finger Stick Lead Level:**

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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						
DTaP-IPV	1	2					
DTap-IPV-Hib	1	2	3				
DTap-HepB-IPV	1	2	3				
DTap-IPV-Hib-HepB	1	2	3				
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					
Human Papillomavirus (HPV)	1	2	3				
Meningococcal Vaccine (ACWY)	1	2					
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
COVID-19 (Recommended)	1	2	3	4	5	6	7
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/them back on schedule.
Next appointment is: _____

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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 (All 3 serotypes) ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal (ACWY) ☐ HPV
☐ COVID-19

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 (All 3 serotypes) ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ 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 i**n 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.** ☐ NA ☐ 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:**

Oral Health Assessment Form

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

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Instructions

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

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

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Student ID _____ Date of Birth (MMDDYYYY): ☐☐/☐☐/☐☐☐☐

Current Gender Identity: _____

Home Address: _____ Home State: ____ Home Zip Code ☐☐☐☐☐

School Grade	Day-care	Pre-K3	Pre-K4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

	Yes	No
1. 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).	☐	☐
2. 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.	☐	☐
3. Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
4. Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
5. Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

6. How many **primary teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns?** ☐☐
7. How many **permanent teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns** ☐☐
   - **c. Extracted due to caries?** ☐☐
8. What type of dental insurance does the patient have? Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

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 childcare 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.

DISTRICT OF COLUMBIA SCHOOL IMMUNIZATION POLICY

All DC students must be up to date on their immunizations before next school year!

1

SCHEDULE YOUR CHILD'S ANNUAL WELLNESS VISIT
Schedule your child's annual wellness visit today, and ask your healthcare provider to complete the Universal Health Certificate. If your child receives an immunization during the visit, ask for written proof of the immunization that you can share with your school.

2

MAKE SURE YOUR CHILD HAS RECEIVED ALL OF THEIR IMMUNIZATIONS
Not sure if your child has received all of their required immunizations? Ask your primary care provider, and request a copy of your child's immunization history to share with your school.

3

SUBMIT IMMUNIZATION DOCUMENTS TO YOUR SCHOOL
Submit the Universal Health Certificate and any other immunization documents to your child's school to guarantee they are ready for next school year. Not sure if your child's school has all the immunization documents they need? Call the school and ask today!

For more information:
OSSE: (202) 727-6436 | DC Health: (202) 576-7130 | bit.ly/DCIAP

OSSE

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