

# DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Mo. /Day/ Yr.

Sex:  Male  Female School or Child Care Facility: \_\_\_\_\_

**Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.**

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
	1	2	3	4	5	6	7
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 Care Provider) <small style="margin-left: 150px;">Name &amp; Title</small>							
Pneumococcal Conjugate							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
Meningococcal Vaccine							
Human Papillomavirus (HPV)							
Influenza (Recommended)							
Rotavirus (Recommended)							
Other							

Signature of Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: MEDICAL EXEMPTION. For Health Care Provider 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 Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider 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 Medical Provider \_\_\_\_\_ Print Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_