

**DISTRICT OF COLUMBIA IMMUNIZATION, TUBERCULOSIS AND LEAD SCREENING CERTIFICATION**

**Part 1: Student's Demographic Data**

Please print information clearly and completely.

Student's Last Name _____	First Name _____	Middle Name _____	Date of Birth _____	Gender <input type="checkbox"/> F <input type="checkbox"/> M
Name of Parent/Guardian _____		Street Address _____		
Home Telephone _____	Work Telephone _____	City _____	State _____	Zip Code _____
School or Child Care Facility _____	Grade _____	Student ID# _____	Student's Social Security Number _____	Student's Medicaid # _____

**Part 2: Immunization Information and Disease History**

Write month, day & year of each immunization given (past or present) Ex: 01/01/93

Diphtheria-Tetanus-Pertussis(<7yr) Circle Vaccine Type Given	DTP/DTaP 1 ____/____/____	DTP/DTaP 2 ____/____/____	DTP/DTaP 3 ____/____/____	DTP/DTaP 4 ____/____/____	DTP/DTaP 5 ____/____/____			
Tetanus-Diphtheria (DT<7 yrs; must have P exemption) (Adult Td >7 yrs) Circle Type Given	DT/Td 1 ____/____/____	DT/Td 2 ____/____/____	DT/Td 3 ____/____/____	DT/Td 4 ____/____/____	DT/Td 5 ____/____/____			
Polio Circle Vaccine Type Given	OPV/IPV 1 ____/____/____	OPV/IPV 2 ____/____/____	OPV/IPV 3 ____/____/____	OPV/IPV 4 ____/____/____	OPV/IPV 5 ____/____/____			
Measles-Mumps-Rubella (MMR) after 1 <sup>st</sup> birthday	1 ____/____/____	2 ____/____/____	Measles		Mumps		Rubella	
			1 ____/____/____	2 ____/____/____	1 ____/____/____	2 ____/____/____	1 ____/____/____	2 ____/____/____
Haemophilus influenzae type b (Hib) vaccine manufacturer _____	1 ____/____/____	2 ____/____/____	3 ____/____/____	4 ____/____/____				
Hepatitis B (Hep B)	1 ____/____/____	2 ____/____/____	3 ____/____/____					
Varicella(chickenpox) Vaccine after 1 <sup>st</sup> birthday	1 ____/____/____	<b>Student's History of Chickenpox Disease</b> May be completed by parent or physician. Leave blank if student has NOT had chickenpox. <i>I certify that, to the best of my knowledge, this student has had the chickenpox disease (date of chickenpox _____).</i>  Signature _____ Date _____ Relationship to student (please circle one): Parent / Guardian / Physician						
	2 ____/____/____							
Other (list type) _____	Other _____	Other _____	Other _____	Other _____	Other _____			

Signature of Certifying Physician/Rep \_\_\_\_\_ Name of Physician/Rep \_\_\_\_\_  
 Date \_\_\_\_\_ Address \_\_\_\_\_

**MEDICAL EXEMPTION FROM IMMUNIZATION:** *I hereby certify that (name of student) \_\_\_\_\_ was not immunized against (disease) \_\_\_\_\_ because (reason) \_\_\_\_\_.*

Signature of Physician \_\_\_\_\_ Name of Physician \_\_\_\_\_  
 Date \_\_\_\_\_ Date Exemption Expires \_\_\_\_\_ Address \_\_\_\_\_

**RELIGIOUS EXEMPTION:** A signed, notarized statement by parent/guardian must accompany this form for any religious exemption.  
**ALL EXEMPTIONS MUST BE APPROVED BY THE DEPARTMENT OF HEALTH.**

**Part 3: Student's Tuberculosis Screening Information**

History of Prior <u>Positive</u> Skin Test	PPD <input type="checkbox"/> Tine <input type="checkbox"/> Date ____/____/____	Result <u>Positive</u>	Chest X-Ray <input type="checkbox"/> Date: ____/____/____	Result: _____
School Entry (Any Grade) TB Test	PPD <input type="checkbox"/> Tine <input type="checkbox"/> Date ____/____/____	Result _____	Chest X-Ray <input type="checkbox"/> Date: ____/____/____	Result: _____
Adolescent (7 <sup>th</sup> Grade) TB Test	PPD <input type="checkbox"/> Tine <input type="checkbox"/> Date ____/____/____	Result _____	Chest X-Ray <input type="checkbox"/> Date: ____/____/____	Result: _____
History of BCG Vaccination	Date ____/____/____	Date ____/____/____	Date ____/____/____	Country _____

Signature of Certifying Physician/Rep \_\_\_\_\_ Name of Physician/Rep \_\_\_\_\_  
 Date \_\_\_\_\_ Address \_\_\_\_\_

**Part 4: Lead Screening Information for Students under 6 Years of Age**

Most recent lead test: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Collection Method: Venipuncture  Fingertick  Result: \_\_\_\_\_  
 If elevated (10 ug/dL or above), action/current status: \_\_\_\_\_

Signature of Certifying Physician \_\_\_\_\_ Name of Physician \_\_\_\_\_  
 Date \_\_\_\_\_ Address \_\_\_\_\_

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH  
OFFICE OF SCHOOL HEALTH SERVICES AND BUREAU OF EPIDEMIOLOGY AND DISEASE CONTROL

**Immunization Regulations and Requirements**

All students admitted to licensed child care facilities, Head Start programs, public and private schools, and post-high school programs in the District of Columbia from preschool through age 25 are required to show proof of current, correctly spaced immunizations against measles, mumps, rubella, polio (until age 18), diphtheria, tetanus, pertussis (whooping cough) (until age 7) and haemophilus influenzae type b (until age 5). Students in certain grades must also show proof of immunizations against hepatitis B and varicella (chickenpox).

**Instructions to Parents/Guardians:** Take this form and any immunization records or information which you have to your physician/health facility; have them fill out the front of this form and return the completed form to the school. Free immunizations are available in the District of Columbia at Walk-In immunization clinics; call the Division of Immunization (202)576-7130 for further information.

**Attention School and Health Personnel:** This Immunization, Tuberculosis and Lead Screening Certification form DHS-826 is the official certification that the student is in compliance with D.C. Law (3-20) and Board of Education Rules. This form must be attached to each student's School Health Record and must be a part of the child's cumulative record at the time of school transfer. Students must meet immunization requirements to enter any grade.

**Instructions on Compliance with D.C. Regulations and Board Rules:** If a parent presents to a school official a "Record of Immunization" as issued by a clinic or private facility, a photocopy may be made and attached to this form; or the data may be transferred by hand by a school official who then must sign his/her name, title, and date. The school official must also indicate where immunizations were given and state that the information was transferred from a record of immunization issued by a medical facility.

Basic Child Care Facility & School Immunization Dose Requirements by Student's Age (see D.C. Law 3-20 and associated regulations for exceptions, required intervals between doses, and additional clarification)				
VACCINE	Under 4 Years	4-6 Years	7-17 Years <sup>1</sup>	18-25 Years <sup>1</sup>
DTP, DT, DTaP, Td	4	5 <sup>2</sup>	3 <sup>3</sup> + 5 <sup>th</sup> grade booster	3 <sup>3</sup> + 10 year boosters
Polio <sup>4,5</sup>	3	4	3	0
Measles, Mumps, Rubella	1	2	2	2
Haemophilus Influenzae type B (Hib)	4 <sup>6</sup>	4 <sup>6</sup> (under 5 yrs old)	0	0
Hepatitis B	3	3 <sup>7</sup> (certain grades)	3 <sup>8</sup> (certain grades)	3 <sup>9</sup> (certain grades)
Varicella	1	1 <sup>10</sup>	1-2 <sup>11</sup> (certain grades)	2 <sup>12</sup> (certain grades)

<sup>1</sup> Requirements if series not previously completed.

<sup>2</sup> A pertussis containing vaccine is required unless there is an approved, pertussis vaccine medical contraindication statement from a physician. 5<sup>th</sup> dose is not required if 4<sup>th</sup> dose was given on or after fourth birthday.

<sup>3</sup> 4<sup>th</sup> dose is required if 3<sup>rd</sup> dose was given less than sixth months after second dose or was given before 4<sup>th</sup> birthday.

<sup>4</sup> Schedules of all OPV or all IPV are acceptable. Final dose of all OPV may be given before the 4<sup>th</sup> birthday. Final dose of all IPV should be given on or after the 4<sup>th</sup> birthday. 4<sup>th</sup> dose of all OPV or all IPV is not required if 3<sup>rd</sup> dose was given on or after fourth birthday.

<sup>5</sup> If sequential schedule of 2 IPV-2 OPV is used, a total of 4 doses are always required; 2<sup>nd</sup> OPV is not required until age 4 but may be given no earlier than 6 weeks after 1<sup>st</sup> OPV.

<sup>6</sup> If PRP-OMP (PedvaxHib by Merck, Sharp & Dohme) vaccine is given for entire series, the 6 month (3<sup>rd</sup>) dose is not required but the 12 month (booster) dose is required; therefore, if using PRP-OMP for entire series, a total of only three doses of Hib vaccine is required. Specify the manufacturer of Hib vaccine given next to the Hib immunization dates.

<sup>7</sup> Beginning in school year 1997-98, 3-dose hepatitis B vaccination is required for all children attending child care, pre-k, & k; in 1998-99 also required for 1<sup>st</sup> grade; 1999-00 for 2<sup>nd</sup> grade; 2000-01 for 3<sup>rd</sup> grade; 2001-02 for 4<sup>th</sup> grade.

<sup>8</sup> Beginning in school year 1997-98, 3-dose hepatitis B vaccination is required for all children attending 5<sup>th</sup>, 6<sup>th</sup> and 7<sup>th</sup> grades; in 1998-99 also required for 8<sup>th</sup> grade; in 1999-00 for 9<sup>th</sup>; in 2000-01 for 10<sup>th</sup>; in 2001-02 for 11<sup>th</sup>; in 2002-03 for 12<sup>th</sup>.

<sup>9</sup> Beginning in school year 2003-2004, 3-dose hepatitis B vaccination is required for all students under age 26, born on or after January 1, 1992, attending their 1<sup>st</sup> year of any post high school program; in 2004-05 also for 2<sup>nd</sup> year; in 2005-06 for 3<sup>rd</sup> year; in 2006-07 for 4<sup>th</sup> year; in 2007-08 for 5<sup>th</sup> year; in 2008-09 for 6<sup>th</sup> year; in 2009-10 for 7<sup>th</sup> year; in 2010-11 for all post-high-school students (regardless of year) up to age 26.

<sup>10</sup> Beginning in school year 1997-98, varicella vaccination or disease history is required for all children attending child care, pre-k, k, 1<sup>st</sup> and 2<sup>nd</sup> grades; in 1998-99 also required for 3<sup>rd</sup> grade; in 1999-00 also required for 4<sup>th</sup> grade.

<sup>11</sup> One dose is required if student receives immunization before age 13; two doses are required if student receives immunization at 13 years or older.

Beginning in school year 1997-98, varicella vaccination or disease history is required for all children attending 5<sup>th</sup>, 6<sup>th</sup> and 7<sup>th</sup> grades; in 1998-99 also required for 8<sup>th</sup> grade; in 1999-00 for 9<sup>th</sup> grade; in 2000-01 for 10<sup>th</sup> grade; in 2001-02 for 11<sup>th</sup> grade; in 2002-03 for 12<sup>th</sup> grade.

<sup>12</sup> Beginning in school year 2003-2004, varicella vaccination or disease history is required for all students under age 26 attending their 1<sup>st</sup> year of any post high school program; in 2004-05 also for 2<sup>nd</sup> year; in 2005-06 for 3<sup>rd</sup> year; in 2006-07 for 4<sup>th</sup> year; in 2007-08 for 5<sup>th</sup> year; in 2008-09 for 6<sup>th</sup> year; in 2009-10 for 7<sup>th</sup> year; in 2010-11 for all post-high school students (regardless of year) up to age 26.

**Tuberculosis Screening Regulations and Requirements**

District of Columbia Board of Education Regulation, Title 5, Section 2003.1 states that students are required to present valid written certification of the results of a current tuberculin screening prior to admission into D.C. public schools or readmission after one or more years absence. Please call the Office of School Health Services Division of School Nursing Services at (202)576-7139 for further information.

**Lead Screening Regulations and Requirements**

D.C. Law 6-66, "The Student Health Care Act of 1985" as amended by D.C. Act 10-61, passed on July 29, 1993, provides that upon entry of a student under 6 years of age into a licensed day care center, Head Start or similar early childhood program, pre-kindergarten, kindergarten, or first grade in a public or private school in the District of Columbia, the student's parent or guardian shall furnish the school with a certificate of testing for lead poisoning. Failure to comply with this act may result in a fine not to exceed \$100. For information call the Lead Poisoning Prevention Program at (202) 727-9850.