# The Britleys for Toddlers

**Part 1: Child's Personal Information** **Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 5 below.**

| Child's Last Name: | Child's First & Middle Name: | Date of Birth: | Gender: M / F | Race/Ethnicity: White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ ☐Other_____ |
|---|---|---|---|---|
| Parent or Guardian Name: | Telephone: | Home Address: | | Ward: |
| Emergency Contact Person: | Emergency Number: | City/State (if other than D.C.) | | Zip code: |
| School or Child Care Facility: | Medicaid Private Insurance None Other _____ | | | Primary Care Provider (PCP): |

**Part 2: Child's Health History, Examination & Recommendations** **Health Provider: Form must be fully completed.**

| DATE OF HEALTH EXAM: | WT ☐ LBS ☐KG | HT ☐ IN ☐CM | BP: (>3 yrs) / ☐ NML ☐ABNL | Body Mass Index (>2 yrs) (BMI)_____ %_____ |
|---|---|---|---|---|
| HGB / HCT *(Required for Head Start)* | Vision Screening Right 20/ Left 20/ | ☐ Glasses ☐Referred | Hearing Screening Pass_____ Fail_____ Referred | |

| HEALTH CONCERNS: | | | REFERRED or TREATED | HEALTH CONCERNS: | | | REFERRED or TREATED |
|---|---|---|---|---|---|---|---|
| Asthma | NO | YES | Referred Under Rx | Language/Speech | NONE | YES | Referred Under Rx |
| Seizure | NO | YES | Referred Under Rx | Development/ Behavioral | NONE | YES | Referred Under Rx |
| Diabetes | NO | YES | Referred Under Rx | Other_____ | NONE | YES | Referred Under Rx |

**A. Significant health history, conditions, communicable illness, or restriction that may affect school, child care, sports, or camp.**

☐ **NONE** ☐ **YES, please detail:** _____

_____

_____

**B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.**

☐ **NONE** ☐ **YES, please detail:** _____

_____

_____

**C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.**

☐ **NONE** ☐ **YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)**

_____

_____

_____

*525 School Street Southwest, Washington DC 20024*
*Phone:202.863.0475 Fax:202.863.0691*
*www.britleystoddlercare.com*

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**Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:**

| | | | | | |
|---|---|---|---|---|---|
| TB RISK ASSESSMENTS | ☐HIGH-><br>☐LOW | Tuberculin Skin Test (TST) DATE: | ☐NEGATIVE<br>☐POSITIVE | If **TST** Positive<br>CXR NEGATIVE<br>CXR POSITIVE<br>TREATED | **Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040 |
| LEAD EXPOSURE RISKS | ☐YES-><br>☐NO | LEAD TEST DATE: | RESULT: | **Health Provider:** ALL lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770 | |

☐**YES** ☐**NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.**

☐**YES** ☐**NO This athlete is cleared for competitive sports.**

☐**YES** ☐**NO Age-appropriate health screening requirements performed within current year. If no, please explain:**

_____

_____

| Print Name | MD/NP Signature | Date |
|---|---|---|
| Address | Phone | Fax |

**Part 4: Required Provider Certification and Signature**

**Part 5: Required Parental/Guardian Signatures. (Release of Health Information)**

**I give permission to the signing health examination/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.**

**Print Name** _____ **Signature** _____ **Date** _____

# The Britleys for Toddlers

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 | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | Chicken Pox Disease History: Yes ☐ When: Month_____Year____<br>Verified by_____(Health Care Provider)<br>Name & Title | | | | |
| Pneumococcal Conjugate | 1 | 2 | 3 | 4 | | | |
| Hepatitis A (HepA) (Born on or after 01/01/2005) | 1 | 2 | | | | | |
| Meningococcal Vaccine | 1 | | | | | | |
| Human Papillomavirus (HPV) | 1 | 2 | 3 | | | | |
| Influenza (Recommended) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Rotavirus (Recommended) | 1 | 2 | 3 | | | | |
| Other | | | | | | | |

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date
Signature of Medical Provider Print Name or Stamp
Date

**Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.**

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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 |