BLESSED SACRAMENT SCHOOL
5841 Chevy Chase Parkway, NW ★ Washington, DC 20015 ★ T: 202.966.6682 ★ F: 202.966.4938 ★ www.bsstoday.com

All Health Records are Due By August 16, 2019
(please mark Health Records on the envelope)

The following guidelines will assist you in having the required Health documentation for your child.

Required Medical Forms: ALL STUDENTS

1. Every student is required to have an *ANNUAL* physical. The District of Columbia Health Certificate is to be completed and signed by a physician or advance practice nurse. This means that your child must have a physical every year within 365 days of the last one and must be current prior to the first day of class.

2. Each student must have a current immunization record, a current physical, an Oral Assessment Form, a yearly Emergency Information Form and a one-time Archdiocese of Washington Immunization Policy Acknowledgement Form on file.

3. All middle school girls are required to have the HPV vaccine or their parents must sign the "HPV opt out" form *every year*.

4. All forms are available on our website (www.bsstoday.org) under the Campus Life-Health Room section. We ask that you make copies and take the proper forms with you to your child's appointment no matter when the appointment is during the year.

5. All students attending school in the District of Columbia must comply with DC health requirements regardless of student's state of residence.

Medication Requirements:

If your child is to take medication at school, have your doctor complete the appropriate Archdiocese Medication Authorization Form which can be downloaded from the Blessed Sacrament School website under Campus Life-Health Room section. EpiPen users please note: in addition to the EpiPen authorization form, an Allergy Action Plan is required.

Please direct any questions regarding the health forms or requirements to the school nurses. Debbie Ryan, RN and Jenny Williams, RN are available each day from 9 am to 2 pm.

Phone: 202-449-4613. Email: healthroom@blessedsacramentdc.org

Blessed Sacrament School

Emergency Information 2019-2020

STUDENT'S NAME (LAST, FIRST, MIDDLE) _____ ☐ MALE ☐ FEMALE

GRADE/ SECTION/ HOMEROOM TEACHER _____ DOB (mm/dd/yyyy) _____

HOME ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ CUSTODY CONCERNS ☐ YES ☐ NO IF YES, CONTACT THE SCHOOL

MALE HEAD OF THE HOUSEHOLD _____ ☐ FATHER ☐ GUARDIAN ☐ OTHER

CELL PHONE _____ BUSINESS PHONE _____

EMAIL _____

FEMALE HEAD OF THE HOUSEHOLD _____ ☐ MOTHER ☐ GUARDIAN ☐ OTHER

CELL PHONE _____ BUSINESS PHONE _____

EMAIL _____

IF PARENT CANNOT BE REACHED, PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

1. NAME _____ PHONE NUMBER _____
2. NAME _____ PHONE NUMBER _____
3. NAME _____ PHONE NUMBER _____

PERSON RESPONSIBLE FOR CHILD AFTER SCHOOL:

NAME _____ PHONE NUMBER _____

ADDRESS _____

FAMILY PHYSICIAN'S NAME _____ PHONE NUMBER _____

FAMILY DENTIST'S NAME _____ PHONE NUMBER _____

HOSPITAL PREFERENCE _____

DOES STUDENT HAVE A HEALTH CONDITION REQUIRING POSSIBLE EMERGENCY CARE? ☐ YES ☐ NO

IF YES, SPECIFY _____

IS STUDENT ON MEDICATION ON A CONTINUING BASIS? ☐ YES ☐ NO

IF YES, PLEASE LIST MEDICATION(S): _____

_____

DOES STUDENT HAVE ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST ALLERGIES: _____

I DO HEREBY AUTHORIZE BLESSED SACRAMENT SCHOOL TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR THE HEALTH OF MY CHILD, _____ . I WILL NOT HOLD BLESSED SACRAMENT RESPONSIBLE FOR THE EMERGENCY CARE AND/OR EMERGENCY TRANSPORTATION FOR THE SAID STUDENT.

PARENT (GUARDIAN) NAME _____ DATE _____

SIGNATURE _____

Print Form

Print Form

FORM 4

IMMUNIZATION POLICY ACKNOWLEDGMENT

ARCHDIOCESE OF WASHINGTON – Catholic Schools

ALL PARENTS OF STUDENTS ATTENDING ARCHDIOCESAN CATHOLIC SCHOOLS IN THE DISTRICT OF COLUMBIA MUST READ THIS FORM, SIGN BELOW, AND RETURN IT TO YOUR CHILD'S SCHOOL WITH THE DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE.

To All Parents of Students in Archdiocesan Catholic Schools in the District of Columbia

It is the policy of the Archdiocese of Washington that all students attending schools in the archdiocese must be fully immunized in accordance with the immunization requirements against contagious diseases published by the local department of health. There are no exemptions permitted. Only if your child has a valid medical contraindication to being immunized against a contagious disease, and such contraindication is documented by a physician, will a temporary exemption be permitted.

Immunization in accordance with the Archdiocese of Washington's policy is a condition for admission into all archdiocesan Catholic schools. To be admitted to attend classes, there must be two forms related to immunization on file at your child's school by the first day of school, and they are:

1. THIS FORM, completed and signed; and
2. DC Universal Health Certificate, signed by a medical provider and parents (Pages 2 and 3).

Acknowledgment

To All Parents/Guardians: Please provide the following information and sign below to acknowledge that you understand and agree to this policy.

Child's Name: _____
Last *First* *M.I.* *(Jr,. III)*

School: **Blessed Sacrament** Sex: ☐ *Male* ☐ *Female* Date of Birth: _____ *mm/dd/yyyy*

Parent/Guardian Name: _____ Home Phone: **( )** **-**

Home Address: _____
Street Address *Suite #*

_____
City *State* *ZIP Code*

I have read and understand the Archdiocese of Washington's Immunization policy listed above:

Parent/Guardian Signature: _____ Date: _____
Please Sign *mm/dd/yyyy*

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

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 ☐ Cell ☐ Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐ Home ☐ Cell ☐ Work	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 ☐ Glasses ☐ Referred Right 20/____ Left 20/____		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
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred							

A. Significant health history, conditions, communicable illness, or restrictions 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)

_____

_____

_____

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

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ 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→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

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

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.

Print Name	Signature	Date

***For use by the Archdiocese of Washington's Catholic Schools in the District of Columbia.**

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						
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_____ Verified by:_____ (Health Care Provider) 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

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

***For use by the Archdiocese of Washington's Catholic Schools in the District of Columbia.**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

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

Instructions

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

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

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

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

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

	Yes	No
Q1 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).	☐	☐
Q2 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.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many of **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many of **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care 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.

ARCHDIOCESE OF WASHINGTON

Archdiocesan Pastoral Center: 5001 Eastern Avenue, Hyattsville, MD 20782-3447
Mailing Address: Post Office Box 29260, Washington, DC 20017-0260
301-853-4500 TDD 301-853-5300

July 9, 2009

Vicar General
and Moderator of the Curia
Phone: 301-853-4520
Fax: 301-853-5346

Re: Immunization information for parents of girls entering sixth grade in archdiocesan schools in the District of Columbia

Dear Parents,

The District of Columbia government has issued new immunization requirements for students, which will take effect in School Year 2009-2010. To implement the new requirements, the District has issued a new immunization form, which is part of the "District of Columbia Universal Health Certificate."

As parents of a rising sixth-grade female student in our Catholic schools, you should know that the District of Columbia Universal Health Certificate allows space for documentation of the new Human Papillomavirus ("HPV") Vaccine, which may be administered by your daughter's physician.[1] While the language of the law describes the change as the "HPV vaccination requirement" you should also know that parents are entitled to "opt out" of the HPV Vaccination for any reason.

The Archdiocese of Washington believes that the primary responsibility for the medical decision of whether or not to vaccinate a young woman against HPV rests with her parents. Your discretion in making this decision with your daughter is critical and should be based on your own well-informed judgment.

In addition to the information provided by the District of Columbia regarding HPV, the Archdiocese would like the parents in its Catholic schools to have access to some consideration of the vaccine against HPV in light of Catholic teaching. As you know from our previous communications regarding the Archdiocesan Immunization Policy, the Church teaches that generally immunizing against disease is a morally responsible action that is important to sustaining the health of our communities. Likewise, there is nothing intrinsically immoral associated with providing or receiving the HPV vaccine. In fact, the National Catholic Bioethics Center issued a statement on vaccination against HPV on July 11, 2006.

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[1] The new law in the District of Columbia found at DCMR 22-146 states:

146.1 Beginning with the 2009/2010 school year, a female student enrolling in grade six (6) for the first time shall receive the first dose of HPV vaccine at age eleven (11) and by age twelve (12).

146.2 The second dose of HPV vaccine shall be administered not less than four (4) weeks after the first dose and by two (2) months after the first dose.

146.3 A third dose of HPV vaccine shall be administered not less than twelve (12) weeks after the second dose and by six (6) months after the first dose.

146.4 The parent or legal guardian of a student required to receive a vaccine under this section may opt out of the vaccination for any reason by signing a form provided by the Department that states that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

It stated the following, which is available at http://www.ncbcenter.org/06-07-11-hpv_vaccine.asp:

> The National Catholic Bioethics Center notes that the Advisory Committee for Immunization Practices has recommended that young women be vaccinated against the human papilloma virus (HPV) as a protection against cervical cancer, which is caused by certain strains of this virus. HPV is spread through sexual contact which includes, but is not limited to, sexual intercourse. Consequently, the most effective way to avoid contracting it is to abstain from sexual relations before marriage and to remain faithful within marriage.
>
> The NCBC considers HPV vaccination to be a morally acceptable method of protecting against this disease, but asks that civil authorities leave this decision to parents and not make such immunization mandatory.
>
> The prevalence of HPV in the reproductive age population makes exposure to the virus possible, even in a monogamous marriage, due to the possibility of a spouse's exposure prior to marriage. Furthermore, we live in a society where non-consensual sex remains a threat to young women who deserve to be protected from the effects of exposure to HPV.

However, as the *Catholic Medical Association Position Paper on HPV Immunization* provides, the HPV vaccine "can help to address one consequence of the spread of HPV, i.e., cervical cancer. At the same time, to best promote the health and happiness of adolescents, physicians, parents and social institutions should redouble their efforts to promote chastity. Consistent messages about and support for this virtue will not only help to reduce disease, but will help individuals, couples, and marriages to flourish."

The Church teaches that parents are the primary caregivers of their children. Because each child is unique, the medical decision regarding the HPV vaccination for your daughter should be made through careful consideration of the medical, ethical and practical information available to your family.

This information is provided in the hope that it might be helpful as you and your daughters make this medical decision.

Faithfully in Christ,

+Barry C. Knestout

Most Reverend Barry C. Knestout
Moderator of the Curia

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 treatment for HPV, but the conditions it causes can be treated.

About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is 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 10,000 women get cervical cancer and 3,700 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 4 major types of HPV. These include 2 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 11-12 years. Doctors may give it to girls as young as 9 years. It is important for girls to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine. However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that girls or women with HPV get vaccinated.

The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a 3-dose series:

- **1st Dose: Now**
- **2nd Dose: 2 months after Dose 1**
- **3rd Dose: 6 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) 576-9342 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Information about Human Papillomavirus and Vaccination and Vaccine Refusal Form for Students at District of Columbia Public, Charter, Private and Parochial Schools			
Instructions for completing HPV Vaccine Refusal Certificate **Section 1:** Enter student information **Section 2:** Have parent/guardian or student (if ≥ 18 years of age) initial, sign and date after reading Vaccine Information Statement (s)			
Name of School			
Section 1: Student Information			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Recent legislation passed in 2007 by the District of Columbia City Council (DC Bill 17-30) requires all female students, enrolling in grade 6 for the first time at a school in the District of Columbia, to submit certification the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine 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 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.

Human Papillomavirus (HPV) Vaccine Refusal

I have received and reviewed the information provided on the human papillomavirus and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, I have decided to not to receive the HPV vaccine for the above named student. I know that I may re-address 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