GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

District of Columbia Immunization Requirements

All students attending school in the District of Columbia must present proof of immunizations by the first day of school. The specific immunization and dosage depends on the child's age and how long ago they were vaccinated. Please use the list below for guidance and check with your child's school nurse or health care provider for additional information.

Requirements for a Child 2 Years or Older Entering Preschool or Head Start

Dosage	Name of Immunization
4	Diphtheria/Tetanus/Pertussis (DTaP)
3	Polio
1	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease.
1	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A
3 or 4	Hib (Haemophilus Influenza Type B) The number of doses is determined by brand used.
4	PCV (Pneumococcal)

Requirements for a Child 4 Years or Older Entering Pre-Kindergarten

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A
3 or 4	Hib (Haemophilus Influenza Type B) The dose is determined by the brand used.
4	PCV (Pneumococcal)

Requirements for a Child 5-10 Years Old Entering Kindergarten thru 5th Grade

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A (if born on or after 01/01/05)

Requirements for a Child 11 Years and Older Entering 6th through 12th Grade

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
1	Tdap (if 5 years since last dose of DTP/DTaP/Td)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
1	Meningococcal
3	Human Papillomavirus Vaccine (HPV) – Female students entering 6th, 7th, and 8th grades only. Parents may sign a vaccine refusal certificate, included in this packet.

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