DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

**Child:** _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

**Parent:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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**Relative or Guardian:** _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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**Person to be contacted in case of an emergency (other than parent/guardian):**

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

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**Designated individual authorized to receive child at end of session:**

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

---

**Signature:** _____ **Relationship to child:** _____ **Date:** _____

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***TO BE COMPLETED BY THE FACILITY***

**Date of Admission:** _____
**Date of Withdrawal:** _____ **Reason:** _____

# District of Columbia Oral Health (Dental Provider) Assessment Form

**Parent/Guardian Instructions:**
**Part 1:** Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
**Part 2:** By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

## Part 1: Child's Personal Information (to be completed by the parent/guardian)

| | | | | |
|---|---|---|---|---|
| Child's Last Name: | Child's First & Middle Name: | Date of Birth: MM/DD/YYYY | Gender: ☐M ☐F | School or Child Care facility: Grade: |
| Parent/Guardian Name 1: | Telephone 1: ☐Home ☐Cell ☐Work | Home Address: | | Ward: |
| Parent/Guardian Name 2: | Telephone 2: ☐Home ☐Cell ☐Work | Emergency Contact: | | Telephone: |
| Race Ethnicity: ☐White Non-Hispanic ☐Black Non-Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other | | | | |
| Primary Care Provider (Medical): | Dentist/Dental Provider: | Type of Dental Insurance: ☐Medicaid ☐Private Insurance ☐None ☐Other | | |

## Part 2: Required Parent/Guardian Signatures

**Parent/Guardian Release of Health Information:**
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

**Dental Provider Instructions:**
**Part 3**: Indicate Circle Yes or No in finding column. For Yes, please explain in Comments Section.
**Part 4** Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

## Part 3: Child's Findings and Parent Recommendations (please indicate in finding column)

CONFIDENTIAL FORM

| | Findings | Comments |
|---|---|---|
| Gingival inflammation | Y N | |
| Plaque and/or calculus | Y N | |
| Abnormal gingival attachments | Y N | |
| Malocclusion | Y N | |
| Treated Dental Caries | Y N | |
| Untreated dental caries | Y N | ☐Check box if Urgent |
| Sealants on permanent molars | Y N | |
| Cleft lip and palate | Y N | |
| Preventative services completed | Y N | What kinds of preventative services were completed? ☐Prophy ☐Fluoride ☐Oral Hygiene |

## Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐is completed ☐is not completed ☐under treatment ☐refused treatment ☐not necessary.
The child has ongoing ☐urgent ☐non-urgent treatment needs and is under treatment ☐by me or ☐has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: **Phone:** **Date:**

**District of Columbia Health Certificate:**
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age or older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.

# 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* *Name/ID Number*_____ | *Primary Care Provider (PCP):* | | |

## Part 2: Child's Health History, Examination & Recommendations

**Health Practitioner: Form must be fully completed.**

| DATE OF HEALTH EXAM: | WT ☐ LBS ☐ KG | HT ☐ IN ☐ CM | BP: (>3yrs) ☐ NML ☐ ABNL | Body Mass Index (>2 yrs) (BMI)_____ %_____ |
|---|---|---|---|---|
| HGB / HCT *(Required for children under age 6)* | Vision Screening Right 20/____ Left 20/____ | ☐ Glasses ☐ Referred ☐ Attempted | Hearing Screening Pass_____ Fail_____ | ☐ Device ☐ Referred ☐ Attempted |

| HEALTH CONCERNS: | | | REFERRED or TREATED | HEALTH CONCERNS: | | | REFERRED or TREATED |
|---|---|---|---|---|---|---|---|
| Asthma | ☐ NO | ☐ YES | ☐ Referred ☐ Under Rx | Language/Speech | ☐ NONE | ☐ YES | ☐ Referred ☐ Under Rx |
| Seizures | ☐ 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**: Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred ☐ **Fluoride Varnish** Date:_____

**A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.**
**☐ NONE ☐ YES, please provide details:**

_____

_____

**B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.**
**☐ NONE ☐ YES, please provide details:**

_____

_____

**C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements. ☐ NONE ☐ YES, please provide details. (For any medications or treatment required during school hours, a Licensed Health Practitioner's Medication Plan or 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 Practitioner:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: **202-698-4040** |
|---|---|---|---|---|---|
| LEAD EXPOSURE RISKS | **LEAD TEST DATE:** | | RESULT: | **Health Practitioner:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: **202-535-2607** | |

## Part 4: Required Licensed Health Practitioner's Certification and Signature

**☐ YES ☐ NO This child has been appropriately examined & health history reviewed and recorded in accordance with the items specified on this form. At time of the 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/APRN/NP Signature | Date |
|---|---|---|
| Address | Phone | Fax |

## Part 5: Required Parental/Guardian Signatures. (Release of Health Information/civil liability waiver)

*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. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.*

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

# DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

**Student Last Name:** **Student First Name:** **DOB:**

**Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's 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 Practitioner) Name & Title | | | | |
| Pneumococcal Conjugate | 1 | 2 | 3 | 4 | | | |
| Hepatitis A (HepA) (Born on or after 01/01/2005) | 1 | 2 | | | | | |
| Meningococcal Vaccine | 1 | 2 | | | | | |
| Human Papillomavirus (HPV) | 1 | 2 | 3 | | | | |
| Influenza (Recommended) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Rotavirus (Recommended) | 1 | 2 | 3 | | | | |
| Other | | | | | | | |

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

**Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner 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 Licensed Health Practitioner | Print Name or Stamp | Date

**Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner 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 Licensed Health Practitioner | Print Name or Stamp | Date

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

***DIVISION OF EARLY LEARNING***
***Licensing and Compliance Unit***

# AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
## (Update Annually)

If my child _____, born on _____/_____/_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ❑ DC ❑MD ❑VA

Child's known Allergies or Physical Conditions: _____
_____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

**Place in child's folder/record.**

# HOMEWORK SUPPORT PLAN AND FAMILY HOMEWORK AGREEMENT

Please review this Homework Support Plan and fill out the Family Homework Agreement together with your child. After completing the agreement, please return it to the Center Director of Site Director to be placed in your child's file.

## Homework Support Plan

- We will provide dedicated time every day for your child to work on his or her homework assignments. Additional activities will be planned and provided during the designated homework time for children who have completed their homework or who do not have homework.

- We will provide a comfortable space that minimizes distractions and encourages children to work on their homework. The space will include materials such as reference books, rulers, calculators, graph paper, pens, pencils, and notebook paper.

- We will do our best to partner with your child's school district and classroom teachers to make use of any school-sponsored support resources and to gain an understanding of expectations for homework assignments.

- We will be available to discuss and answer question regarding your child's effort completing his or her homework.

- We will keep the completed Family Homework Agreement on file and refer to it as needed to remind your child of your agreement as a family and how he or she can use the homework support provided by this program.

**Please note that your child's homework assignments must be completed online or digital format, we may not be able to assist him or her with completing them.**

# Family Homework Agreement

Child's Name: _____

Name of School: _____

Name of Grade Level Teacher: _____

Age: _____ Grade: _____

Child

**I understand it is my responsibility to:**

- ✓ Have a list of all of my homework assignments and know what is expected to complete them.
- ✓ Bring the materials necessary to complete my homework assignments.
- ✓ Ask when I need homework help or have a question.

**Circle the statement that best describe where, when, and how you prefer doing your homework:**

| | | |
|---|---|---|
| In a quiet place | Or | In a place where I can talk and move around while I work |
| At a table | Or | On a couch or on a beanbag chair |
| Do homework first | Or | Do homework after snack and time to run or relax |
| Work alone | Or | Work in a small group |

**Which homework assignments are usually the easiest for you?**

_____

_____

_____

**Which homework assignments are usually the hardest for you?**

_____
_____
_____

**Please complete this sentence:**

When I get stuck on my homework, it helps when an adult _____

_____
_____

Parent or Guardian

I understand it is my responsibility to:

- ✓ Verify the accuracy of completed homework assignments and assist with any additional homework assignments.
- ✓ Communicate with my child and the program staff as needed to ensure my child is taking advantage of the support and resources provided by the program.

**When my child get stuck on homework, it helps when I _____**

_____
_____
_____
_____

**When my child gets stuck on homework, it does NOT help when I _____**

_____
_____
_____
_____

**What type of assistance is most often needed when helping your child complete homework?**

- ☐ Understanding assignment instructions
- ☐ Organizing time and/or assignments
- ☐ Memorizing or practicing facts
- ☐ Understanding content of assignments

**As a family, we have discussed the Homework Support Plan and Family Homework Agreement and have decided our child will:**

- ☐ Work on homework at home
- ☐ Take full advantage of the homework time provided by the program and work on all subjects for which homework is assigned
- ☐ Take full advantage of the homework time provided by the program, but will focus on the following subject(s): _____
  _____
  _____
  _____
  _____
  _____

_____ _____

Child's Signature Date

_____ _____

Parent's/ Guardian's Signature Date

I have received and read the 2018-2019 Champions Parent Handbook (online contracted term)

_____
Parent/Guardians Signature

_____
Child's Name

_____
Date

He recibido y leído el Manual para Padres de Campeones 2018-2019 (término contratado en línea)

_____
Firma del padre / tutor

_____
El nombre del niño

_____
Fecha

Parents Information

Child's Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____

Cellular Phone: _____

Work Phone: _____

Anything I need to know about your child? _____

_____

_____

_____

_____

_____

_____

_____

_____

DISTRICT OF COLUMBIA
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EDUCATION

# TRAVEL AND ACTIVITY AUTHORIZATION

❑ Special one time permission for this activity only ❑ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

**Trips in the van/automobile** (facility or parent - owned)

_____
Explain planned activity - where and when

**Field trips away from the facility**

_____
Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

❑ I will allow my child to play outside the fenced area; or

❑ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

**PLEASE KEEP A COPY IN THE CHILD'S FILE.**