DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

April 1, 2014

Dear DCPS Families,

As you prepare to enroll your child in District of Columbia Public Schools (DCPS) for the 2014-2015 School Year, I want to take a few moments to share some exciting news about the progress we have made as a school system and some of the improvements we are planning for the upcoming school year.

First, our students are making incredible strides academically. With a robust new curriculum and outstanding educators, our students have made progress any way you look at it. DC outpaced other states on the National Assessment of Educational Progress (NAEP), the "Nation's Report Card." And our scores on this exam have never been higher. This is exciting news that reflects the hard work of our students and teachers and underscores our commitment to providing our students the rigorous curriculum and world-class instruction they deserve and need to succeed in college and in life.

Second, we are investing in our school like never before. Over the past few years, we have spent hundreds of millions to modernize our buildings, we have attracted, hired and retained high-quality educators, and we have provided our students with the resources they need to succeed and enjoy learning. For next school year, we are offering $5 million in new Proving What's Possible for Student Satisfaction awards in which schools can apply for grants to help make school more enjoyable for students. We are extending the school day in some schools to give students more learning time. All said, there is greater than $50 million more going directly into schools next year. I am excited to see what our schools can do with this new award and how they expand their options to make schools fun and exciting for students.

Finally, our continued work toward providing a quality educational experience for all students has resulted in increased interest and excitement for our school system. This year, we saw another enrollment increase with more and more District families are choosing our schools. Clearly, we are on the rise and I am more than pleased that you and your family have decided to join us.

Why is it important to enroll early?
Early enrollment helps us project the number of students for each school, which then allows us to hire the proper number of staff, and to order the correct number of textbooks and supplies. Ultimately, early enrollment helps facilitate a smooth opening to the school year. Here are some key enrollment dates:

- **April 1:** Enrollment begins.
- **May 1:** All enrollment packet material due for families who applied in the Common Lottery.
- **June 20:** Deadline for enrollment (all forms must be returned to your child's SY 2014-2015 school).

Please fill out the enclosed forms and bring them to your child's school as soon as possible. If you have any questions, please do not hesitate to contact your child's school directly or the DCPS Office of Student Enrollment & School Funding at (202) 478-5738.

Thank you for choosing to send your child to one of our schools for the 2014-2015 school year. I look forward to an engaging school year, and I am excited about working with you to meet your child's learning needs.

Sincerely,

Kaya Henderson
Chancellor

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Welcome to School Year 2014-2015!

Student Enrollment and Health Forms:

- Enrollment forms have been printed to include your child's previously submitted information. If the information has changed or is incorrect, please make changes directly on the form and review with your school's principal/registrar.
- You can locate all documents online at www.dcps.dc.gov/enroll. (Translations are available in Spanish, French, Chinese, Vietnamese and Amharic).
- For a listing of feeder school options to help you identify your child's new school, visit www.dcps.dc.gov/enroll.

If you have any questions about completing your enrollment packet, please do not hesitate to contact your child's school directly or the Chancellor's Response Team at 202-478-5738.

	Student Enrollment and Health Forms 2014-2015: Below is the index of all items in the 2014-2015 Enrollment Packet. **Items marked "Required" must be turned in to your child's 2014-2015 school in order to complete the enrollment process.**	**Parent/ Guardian ✓**	**School Official ✓**
Enrollment Requirements	All students enrolling in DCPS must return forms below to their 2014-2015 school by June 20, 2014 (or May 1, 2014, for students who received a seat through the My School DC Lottery).		
	• **Annual Student Enrollment Form** (Required)....Page 3	☐	☐
	• **Residency Verification Guidelines** (Additional form requiring signature available at school - Required)....Page 4	☐	☐
	• **Home Language Survey** (Required)....Page 5	☐	☐
	• **Consent Forms**....Page 7 ▪ **Media Release** (All Students, Required) ▪ **Military Recruitment Opt-Out** (Grades 7-12 ONLY, Optional)	☐	☐
Age Verification: NEW Students ONLY	Students NEW to DCPS must provide ALL of the forms above, plus: • Proof of age documentation. Provide ONE of the following: ▪ Birth Certificate ▪ Hospital Records ▪ Previous School Records ▪ Passport ▪ Baptismal Certificate	☐	☐
Health Forms and Information	Forms marked "Required" must be filled out by health provider and returned at the time of enrollment:		
	• **School Health Checklist**....Page 9	☐	☐
	• **DCPS Immunization Requirements 2014-2015**....Page 10	☐	☐
	• **DC Universal Health Certificate Instructions and Form** (Required)....Page 12	☐	☐
	• **DC Oral Health Assessment Form** (Required)....Page 16	☐	☐
	• **Human Papilloma Virus (HPV) Information** (Grades 6-11 ONLY)....Page 18	☐	☐
	• **HPV Vaccination Opt-Out Certificate** (Optional)....Page 19	☐	☐
Optional Forms	*Optional or Informational Forms not required for enrollment process:*		
	• *Free and Reduced Price Meal (FARM) Application Notification*....Page 20	☐	☐
	• *Special Dietary Needs and Accommodations Form*....Page 21	☐	☐
	• *FERPA Notification*....Page 22	☐	☐

_____ _____

Parent/Guardian Signature and Date School Official Signature and Date

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

ANNUAL STUDENT ENROLLMENT FORM
School Year 2014 - 2015

Grade in School Year 2014 - 2015: ☐ **School in SY 2014 - 2015:** _____

DCPS Student ID #: _____ **(Print all information)**

STUDENT INFORMATION

1. Last Name	2. First Name	3. Middle Name	4. Country of Birth	5. Date of Birth

6. Address	7. Apt. No.	8. Home Telephone Number

9. City	10. State	11. ZIP Code

12. Student's Gender: ☐ Male ☐ Female ☐ Decline to Respond

13. Student's Home Language(s):

14. School Last Attended:

☐ Private ☐ Public ☐ Charter ☐ Other

Dates Attended: Month/Date/Year _____ - _____

Previous School Address:

City	State	ZIP Code

15. Health Insurance or Medicaid Information
Provider: _____ Policy Number:_____
List any medical conditions of which the school should be aware.

For students new to DCPS, please indicate whether or not your child has a(n):
IEP (Individualized Education Program) **Yes☐ or No☐** If yes, IEP review date: _____
Section 504 Accommodation Plan **Yes☐ or No☐**

16. Student's Siblings	A.	B.	C.
Student's Siblings' Schools			

17. Ethnic Designation:
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

17b. Race - choose one or more
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native ☐ Asian ☐ White

PARENT/GUARDIAN INFORMATION AND OTHER PRIMARY CAREGIVER INFORMATION*

18. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military	19. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military
Address		Apt. No.	Address		Apt. No.
City	State	ZIP Code	City	State	ZIP Code
Email Address	Preferred Language of Communication		Email Address	Preferred Language of Communication	
Cell Number	Work Number		Cell Number	Work Number	
Employer's Name/Address			Employer's Name/Address		
City	State	ZIP Code	City	State	ZIP Code

EMAIL AND TEXT COMMUNICATION*

20. ☐ I would like to receive email messages from my child's principal and DC Public Schools at the address listed above OR the address listed below.
Email address: @

☐ I would like to receive text messages from DC Public Schools at the number listed above OR the number listed below. I understand standard messaging and data rates may apply. Cell phone number: ( )

IN CASE OF EMERGENCY

21. Emergency Contact Person (other than parent/guardian)	Relationship	Home Number ( )		Work Number ( )
Address	City	State	ZIP Code	Cell Number ( )

RESIDENCY STATUS (CHECK ONE ☑)

22. ☐ D.C. Resident (Student and parent or guardian live in D.C.) ☐ Nonresident

HOUSING STATUS (CHECK ALL THAT APPLY ☑)

23. ☐ Permanent	☐ Hotel/Motel	☐ Doubled Up	☐ Awaiting Foster Care
☐ Shelter	☐ Unsheltered	☐ Foster Care	☐ Unaccompanied Youth

** DCPS agrees that the data/information provided in the Student Enrollment Form remain confidential and shall only be used for legitimate DCPS business.*
I completed this form and I certify that the information above is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law. Form should not be signed prior to April 1. Information provided on this form should be applied consistently throughout enrollment documentation.

_____ _____
***Signature of Parent/ Guardian with Whom Student Lives or Student Who is 18 or Older.** **Date**

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

RESIDENCY VERIFICATION GUIDELINES

Every school year, parents/guardians and other primary caregivers are required to verify D.C. residency for every registering student. The following guidelines provide a comprehensive view of the required documentation for proving residency in the District of Columbia for School Year 2014-2015.

Other primary caregivers are also required to present documentation that attest to their eligibility to enroll and verify residency for a student. Check with your local school for a listing of required documents.

Procedures for the Establishment of Residency

- Establish residency within 10 days of the time of initial enrollment. This verification shall take place no sooner than April 1st of the current school year (April 1, 2014).
- Provide *original documents* to the school representative as proof of residency. **Documents must be in the name of the enrolling parent or legal guardian**. Schools are required by law to copy your original documents for audit purposes.
- School official will provide an additional residency verification form that must be signed by the same enrolling parent/guardian/caregiver whose name appears on residency documents submitted at the time of enrollment.

REQUIREMENTS FOR PROVING RESIDENCY (OPTION 1)

ONE OF THE FOLLOWING ITEMS indicating name and address will suffice to establish District of Columbia residency:	
1. A **pay stub issued within 45 days, with your DC Address and DC tax withholding**	5. Proof of **financial assistance from the DC Government**
2. **Supplemental Security Income annual benefits notification**	6. A **copy of D-40 form certified** by the DC office of Tax & Revenue form
3. **Verification Letter** *and* **Military Housing Orders;** or **DEERS Statement**	7. Proof that the child is a **ward of the District Columbia**, in the form of a **Court Order**
4. An **embassy letter** indicating embassy sponsored housing in DC, embassy seal affixed	

REQUIREMENTS FOR PROVING RESIDENCY (OPTION 2)

***In the absence of items listed in Option 1, two (2) of the items listed below indicating name and address* will suffice as proof of residency in the District of Columbia. The address and name on each submitted item must be the same.**	
1. Unexpired **DC motor vehicle registration**	3. Unexpired **lease or rental agreement with receipt of payment** within two months
2. Unexpired **DC motor vehicle operator's permit** or their official non-driver identification	4. **One utility bill** (only gas, electric and water bills are acceptable) **with receipt of payment** within two months

Documents shown on the Residency Verification Form and in these guidelines are acceptable for proving DC residency; alternative documents are not accepted. For questions or guidance, please call DCPS Office of Student Enrollment & School Funding- Student Residency Office, located at 1200 First Street, 9th Floor, (202) 442-5215.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Home Language Survey (HLS) Form

Complete this Home Language Survey at the Student's initial enrollment in a DC Public School.
This form must be signed and dated by the Parent or Guardian. This form must be kept in the student's file.

School: _____ **Student ID #:** _____

Student's Last Name: _____ **Student's First Name**_____

English

1. **Is a language other than English spoken in your home?**
   ☐ **No** ☐ **Yes** _____ **(specify language)**
2. **Does your child communicate in a language other than English?**
   ☐ **No** ☐ **Yes** _____ **(specify language)**
3. **What is your relationship to the child?**
   ☐ **Father** ☐ **Mother** ☐ **Guardian** ☐ **Other (specify)**_____

If the answer to question 1 or 2 is "Yes", the law requires your child's English language proficiency to be assessed.

REGISTRAR PROCESS:

- If a parent/guardian does not speak English and your school does not have staff that speaks the parent/guardian's language, please use the Language Line for communication.
- If the HLS indicates a language other than English is spoken in the home, give the family the Referral Letter and refer the family to the Intake Center for assessment and orientation.

Español (Spanish)

1. **¿Se habla otro idioma que no sea el inglés en su casa?**
   ☐ **No** ☐ **Sí** _____**(idioma)**
2. **¿Habla el estudiante un idioma que no sea el inglés?**
   ☐ **No** ☐ **Sí** _____**(idioma)**
3. **¿Cuál es su relación con el estudiante?**
   ☐ **Padre** ☐ **Madre** ☐ **Guardián** ☐ **Otro (especifique)**_____

Si la respuesta a la pregunta 1 ó 2 es " Sí ", la ley requiere que se evalúe la fluidez de su hijo/a en el idioma inglés.

Français (French)

1. **Parlez-vous une langue autre que l'anglais à la maison ?**
   ☐ **Non** ☐ **Oui** _____ **(spécifiez la langue)**
2. **Votre enfant communique-t-il dans une langue autre que l'anglais ?**
   ☐ **Non** ☐ **Oui** _____ **(spécifiez la langue)**
3. **Quel est votre relation avec l'enfant ?**
   ☐ **Père** ☐ **Mère** ☐ **Tuteur** ☐ **Autre (spécifiez)** _____

Si la réponse à la question 1 ou 2 est " Oui " , la loi exige que les compétences de votre enfant en anglais soit évaluées.

中文 (Chinese)

1. 您家庭中是否使用不是英语的另外一种语言?
   ☐ 否 ☐ 是 _____ (请指明语言)
2. 您的孩子会使用不是英语的另一种语言交流吗?
   ☐ 不会 ☐ 会 _____ (请指明语言)
3. 您和孩子的关系是什么?
   ☐ 父亲 ☐ 母亲 ☐监护人 ☐其它(请指明) _____

如果第一或第二项问题的答案为"是"，法律要求评估您孩子的英语熟练能力。

Tiếng Việt (Vietnamese)

1 **Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?**
   ☐ **Không** ☐ **Có** _____ **(xin ghi rõ ngôn ngữ nào)**
2 **Con em quý vị có nói một ngôn ngữ nào khác ngoài tiếng Anh không?**
   ☐ **Không** ☐ **Có** _____ **(xin ghi rõ ngôn ngữ nào)**
3. **Xin cho biết liên hệ của quý vị với con em?**
   ☐ **Cha** ☐ **Mẹ** ☐ **Giám hộ** ☐ **Liên hệ khác (xin ghi rõ)**

_____

Nếu trả lời của câu hỏi 1 hoặc 2 là " Có ", luật lệ đòi hỏi con em quý vị phải được thẩm định trình độ thông thạo Anh ngữ.

አማርኛ (Amharic)

1. **በቤትዎ ውስጥ ከእንግሊዘኛ ሌላ የሚነገር ቋንቋ አለ ?**
   ☐ **የለም** ☐ **አዎን** _____ **(ቋንቋውን ይጥቀሱ)**
2. **ልጅዎ ከእንግሊዘኛ ሌላ የሚነጋገርብት ሌላ ቋንቋ አለ?**
   ☐ **የለም** ☐ **አዎን** _____ **(ቋንቋውን ይጥቀሱ)**
3. **ስልጁ ያለዎት ዝምድና ምንድን ነው?**
   ☐ **አባት** ☐ **እናት** ☐ **አሳዳጊ** ☐ **ሌላ**_____ **(ይግለጹ)**

ለጥያቄ 1 ወይም 2 መልስዎ "አዎን" ከሆነ ፣ የልጅዎ የእንግሊዘኛ ቋንቋ ቅልጥፍና ችሎታው ደረጃ እንዲገመገም ህጉ ያዛል።

School Official's Comments:

_____ _____

School Official Signature **Date** **Parent/Guardian Signature** **Date**

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Consent and Release for Student to be Filmed/ Photographed/ Interviewed and for Use of Image/Voice

I, Parent/Guardian , hereby irrevocably grant to District of Columbia Public Schools (DCPS) and the District of Columbia, their successors, and their assignees the right to record the image and/or voice and use the artwork and /or written work of my child, Student Name , on videotape, on film, in photographs, in digital media and in any other form of electronic or print medium and to edit such recording at their discretion.
I understand that my child's full name, address and biographical information will not be made public. I further grant (DCPS) and the District of Columbia, their successors, and their assignees the right to use, and to allow others to use, my child's image and/or voice on the Internet, in brochures, and in any other medium and hereby consent to such use.

I hereby release DCPS and the District of Columbia, their successors, and their assignees and anyone using my child's image and/or voice, artwork and/or written work pursuant to this release from any and all claims, damages, liabilities, costs and expenses which I or my child now have or may hereafter have by reason of any use thereof.

I understand that the provisions of this release are legally binding (check one). ☐ **I consent.** ☐ **I do not consent.**

_____ _____
Parent/Guardian Name [Printed] **Signature of Parent/Legal Guardian or Student** (if an adult)

_____ _____ _____
Date **Student's School** **Student Grade**

Right to Opt Out of Release of Information to Military Recruiters (Students in Grades 7–12 & Ungraded Students Only)

Federal laws require that local education agencies (LEAs) such as DCPS provide military recruiters, upon request, with the name, address and telephone number of all secondary students unless the parent/legal guardian of a student (or the student if an adult) has advised the LEA in writing that he/she does not want the student's information disclosed without prior written consent. Such advisement by the parent/legal guardian (or adult student) must take place within 30 days of the notification of these rights, and may be done by checking one of the appropriate options below, signing this form and returning it to DCPS.

_____ As the parent/legal guardian for the child named below, I request that DCPS not release the name, address, and telephone number of my child to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.
_____ As an adult student (who has reached the age of 18), I request that DCPS not release my name, address, and telephone number to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.

_____ _____
Student's Name Printed **Signature of Parent/Legal Guardian or Student** (if an adult) and **Date**

_____ _____
Student's School **Student Grade**

Notice of Non-Discrimination *In accordance with state and federal laws, the District of Columbia Public Schools does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business. For the full text and additional information, visit http://dcps.dc.gov/DCPS/About+DCPS/Human+Resources/Notice+of+Non-Discrimination.*

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Health Checklist, School Year 2014-2015

Please turn in the following forms to the **Registrar** at your child's school when you enroll your child. DC law requires that all students be current on immunizations to attend school. DC law also requires Universal Health Certificates for children enrolling in all grades and Oral Health Assessments for children in selected grades.

Form	Description	Required	Notes
Universal Health Certificate	Two-page form, and two-page instructions for your medical provider	Students enrolling in all grades (PK3-12th).	Have your child's physician or nurse practitioner complete the Universal Health Certificate. The Universal Health Certificate must document immunizations, tuberculosis assessment and physical completed within 365 days before the start of school. Every child less than six years of age must be tested **twice** for blood lead poisoning. Testing must be completed, regardless of exposure risk, and documented on Universal Health Certificate. If your child participates in athletics, the certificate will expire 365 days from the date of the exam listed on the form. To remain eligible for athletics, an updated Universal Health Certificate must be submitted to the school when a new physical occurs. (Need health insurance? You many qualify for Medicaid or subsidized health insurance. Visit https://dchealthlink.com for more information.)
Immunization Documentation	Age-appropriate immunizations must be documented on the Universal Health Certificate. A one-page flier of required immunizations is included.	Students enrolling in all grades (PK3 – 12th). After 10 days of school, students who have not submitted their immunizations will be excluded from classes and supervised separately.	Please schedule a visit with your child's physician soon if your child's immunizations are not up to date. Some immunizations require more than one dose with return visits. If you have questions about DC's immunization requirements, please discuss them with your child's physician. You can also contact the DC Department of Health Immunization Division at 202-576-9325.
Oral Health Assessment Form	One page	Students enrolling in all grades (PK3-12th).	Have your child's dentist complete this form. (Need dental insurance? You many qualify for Medicaid or subsidized health insurance. Visit https://dchealthlink.com for more information.) (Have Medicaid, but need help finding a dental provider or making an appointment? Call 1-866-758-6807 or visit http://www.insurekidsnow.gov/state/dc/district_oral.html)
HPV Vaccine Opt-Out Form	Included is an HPV Vaccine Opt-Out form and an explanation of the vaccine (two pages)	Students in grades 6-11.	If you decide your child in grades 6-11 will not get the HPV vaccine, please turn in the HPV vaccine-refusal form. If you need to file an exemption for other vaccines, please contact your child's school nurse.
Medication Orders	There are required forms in order for the school to meet your child's medication or medical intervention needs. You can get these forms from your school nurse or online at: www.dcps.dc.gov	Students who need medication or medical intervention during the school day for asthma, allergies, diabetes, seizures, or other medical conditions. If this applies to your child, please speak with your principal and nurse about your child's physical health or behavioral health condition and intervention requirements.	To ensure that your child's medication needs are met while at school, please refer to *Meeting Your Child's Medication and Treatment Needs at School,* for detailed information. This can be found at http://tinyurl.com/qhjbhms. Whenever possible, administer medications at home. If your child needs to take medication or requires medical treatment during school hours, please have your medical provider complete the appropriate forms – there's the Medication and Treatment Authorization Form, the Asthma Action Plan and the Action Plan for Anaphylaxis. These forms are available on the DCPS website at http://tinyurl.com/qzjsu6t and from your school's nurse. If you have any questions about which form is needed for your child, please speak with your school's nurse. If your child needs a dietary accommodation, your provider should also complete the Special Dietary Needs Form. This form is available on the DCPS website at http://tinyurl.com/kwf8386. Students allowed to self-administer medications for asthma, anaphylaxis, or diabetes while at school must also have a medication action plan signed by the student's parent or guardian, and physician.

If you have any questions, please feel free to contact Diana Bruce, DCPS Director of Health and Wellness: 202-442-5103 or Diana.Bruce@dc.gov. You can find copies of these forms on the DCPS website.

District of Columbia Immunization Requirements[1]
School Year 2014 – 2015

All students attending school in the District of Columbia must present proof of appropriately spaced immunizations by the first day of school.

A Child 2 years or older entering
Preschool or Head Start

- **4** Diphtheria/Tetanus/Pertussis (DTaP)
- **3** Polio
- **1** Varicella (chickenpox) – if no history of disease[2]
- **1** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 4 years old entering
Pre-Kindergarten

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 5 – 10 years old entering
Kindergarten thru Fifth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A (if born on or after 01/01/05)

A student 11 years & older entering
Sixth thru Twelfth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP/Td)
- **1** Tdap
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **1** Meningococcal
- **3** Human Papillomavirus Vaccine (HPV) –Students in grades 6 thru 11 or parent may sign approved vaccine refusal form available at www.doh.dc.gov

[1] At all ages and grades, the number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's school nurse or health care provider for details.

[2] All Varicella/chickenpox disease histories MUST be verified/diagnosed by a health care provider (MD, NP, PA, RN) and documentation MUST include the month and year of disease.

[3] The number of doses is determined by brand used.

Rev 02-14

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form r*eplaces a*ll forms dated before February 24, 2009. This District of Columbia Universal Health Certificate (DCUHC) will be used for entry into Child Care Facilities, Head Start and DC public, private and parochial schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DCUHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) guidelines for child and adolescent preventive health care; from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.

General Instructions: Please use a black ball point pen when completing this form.

Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which the address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. If the child's type of insurance coverage is not listed, check "other" and write the type of coverage in the space provided. Write the name of your child's primary care provider (doctor). If your child does not have a primary care provider, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**

Part 2: Child's Health History, Examination & Recommendations: (To be completed by the health care provider). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate the date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is 2 years of age or older, the BMI has to be calculated and recorded inclusive of percentile.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is ***required* for Head Start children**. Also, anemia screening is recommended for menstruating adolescents based on AAP guidelines. Please record blood level and indicate which test was performed by circling HGB, HCT or both.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO/NONE "HEALTH CONCERNS", then check the **'NO" or None"** box in each health screening area.
- **SPECIAL NOTE:** "Annual Dentist Visit" – for children three years of age and older, the health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No", the child should be referred to a dentist.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE"**.**
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE"**.**
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark
- "NONE"**.**
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Physician's Medication Authorization Order and attached it to the health certificate.

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

• **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2006 AAP RED BOOK, 27th Ed., page 682.* Current DC regulations require one TST (Tuberculin Skin Test) for all children entering child care or school; whichever comes first. TST is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note the test and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and whether the child was treated. **All positive TSTs must be reported to the DC T.B. Control Program on 202-698-4040.**
• **LEAD EXPOSURE RISKS:** DC law requires that all children are tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6. Please document both the "Date" and "Result" of most recent lead test. Please indicate if "Pending." "Pending" results will be **valid for two months from date of testing** and will not exclude a child from school-related activity or program. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead Poisoning Prevention Program. For detailed instructions, call 202-654-6036/6037**. **Providers may fax results to: 202-481-3770.**

Part 4: Required Provider (physician or nurse practitioner) Certification and Signature:
The provider will respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation 2nd Ed. (1997; and The child has received age-appropriate screenings (in accordance with AAP and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.

Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the health provider to share the health information on this form with the child's school, child care facility, camp or appropriate DC Government agency.

Forms are available online at **www.doh.dc.gov**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION

General Instructions: Please use black ball point pen when completing form

Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature and date. As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised May 2, 2008), the following immunizations are required.

Instructions: Find the age of the child/student in the column labeled "Child's Current Age". Read across the row for each required vaccine. The number in the box is the number of doses required for that vaccine based on the CURRENT age or grade level of the child. The age range in the column does not mean that the child has until the highest age in that range to meet compliance. Any child whose age falls within that range must have received the required number of doses based on his/her CURRENT age in order to be in compliance.

Vaccine types and dosage numbers required for children enrolled in Child Care Programs[1, 2]

Child's Current Age	DTaP/DTP/DT	Polio	Hib[7]	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate[12]	Meningococcal	Human Papillomavirus (HPV)
Less than 2 months	0	0	0	0	0	1	0	0	0	0
2 – 3 months	1	1	1	0	0	1	0	1	0	0
4 – 5 months	2	2	2	0	0	2	0	2	0	0
6 – 11 months	3	3	2 / 3	0	0	3	0	3	0	0
12 – 14 months	3	3	3 / 4	1	1	3	1	4	0	0
15 – 23 months	4	3	3 / 4	1	1	3	1	4	0	0
24 – 47 months	4	3	3 / 4	1	1	3	2	4	0	0
48 – 59 months	5[3]	4[6]	3 / 4	2	2	3	2	4	0	0

Vaccine types and dosage numbers required for children enrolled in Public, Charter, Parochial and Private Schools[1, 2]

Grade Level		DTaP/DTP/DT/ Td/Tdap	Polio[6]	Hib	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate	Meningococcal[13]	Human Papillomavirus[14] (HPV)
Grade	(Ungraded)										
Grades K – 5	(5 – 10 yrs)	5[3, 4]	4	0	2	2	3	2	0	0	0
Grades 6 - 12	(11 – 18+ yrs)	6[4, 5]	4	0	2	2	3	2	0	1	3

[1]Spacing: Doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day, must be separated by a minimum of 28 days.

[2]Exemptions: Medical exemptions from immunizations may be granted for valid reasons with proper documentation from health care provider (Section 2). Blood titers may be obtained in lieu of immunizations (Section 3). A copy of the lab report must be submitted to school/child care facility. Documentation for religious exemptions must be submitted by parent/guardian to the school/child care facility.

[3]DTP/DTaP: Five (5) doses of DTP/DTaP are required at 4 years of age for school entry unless 4th dose was given on or after the 4th birthday. Interval between dose 4 and dose 5 of DTP/DTaP must be 6 months.

[4]Td/Tdap: Three (3) doses of Td required if primary series started after 7th birthday. If ≥11 years old, one of three doses must be tetanus, diphtheria, and pertussis (Tdap) vaccine dose. Tdap booster required five years after last dose of tetanus, diphtheria-containing vaccine. Td booster required every 10 years.

[5]Tdap: Student must meet the minimum prior requirement for the 4th or 5th doses of DTP/DTaP vaccine and have one (1) dose of Tdap.

[6]Polio: Four doses are required at age 4 for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are required to complete the primary series. Polio is not routinely given for students ≥ 18 years of age.

[7]HIB: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age, however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.

[8]MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and Varicella must be given on the same day or separated by 28 days.

[9]Varicella: Second dose required at 4 years of age. First dose must be given on or after the first birthday. If first dose given between 12 months and 12 years of age, second dose is given 3 months after first dose; if first dose is given at ≥ 13 years, 2nd dose may be given one month after first dose. The Varicella vaccine is not required for a student who has a history of chickenpox verified by a primary care provider and includes the month and year of disease.

[10]Hepatitis B: If monovalent hepatitis B vaccine is given in conjunction with a combination vaccine, i.e. DTaP-IPV-Hepatitis B, four doses of hepatitis B is acceptable; however, dose 3 or 4 must be given at age 24 weeks or later and at least 8 weeks after the previous dose. If monovalent hepatitis B vaccine is administered, dose 3 must be given at least 16 weeks after dose one and at least 8 weeks after dose 2. For students 11-15 years old, a clearly documented 2-dose adult hepatitis B vaccine (Recombivax) is acceptable.

[11]Hepatitis A: Required for students born on or after January 1, 2005.

[12]Pneumococcal: The number of pneumococcal doses required depends on the student's current age and the age when the first dose was administered. Administer 1 dose to healthy children aged 24 through 59 months who are not completely vaccinated for their age. The vaccine is not required for students 5 years of age and older.

[13]Meningococcal: Required at age 11 years of age and older.

[14]HPV: Required for students entering the sixth grade for the first time. Information concerning human papillomavirus (HPV) and the HPV vaccine must be provided to parent/guardian or student. A parent/guardian may sign a form approved by the Department of Health to "Opt-Out".

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name or stamp and date this section.

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 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

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**

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

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 ❑ Asia 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: Circle Yes or No in findings 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 findings 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 and 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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007), the parent or legal guardian of a student enrolling in grades 6 through 11 for the first time at a school in the District of Columbia is required to submit certification that 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 with 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.

Section 2: Signatures

Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress 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

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 cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually 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 12,000 women get cervical cancer and 4,000 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 four major types of HPV. These include two 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 and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six 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).

Free And Reduced Price Meals (FARM) Application

School breakfast, after school snack, and after school supper are free for all students. For school year 2014-15, approximately 75 schools will be certified for the Community Eligibility Provision (CEP), which allows all children at those schools to receive lunch meals at no charge. Households in which all students attend CEP schools are not required to submit a FARM application for 2014-15. For schools that are certified by the CEP, refer to the DCPS website.

In order to qualify for free or reduced price meals, a FARM Application must be completed. One FARM application should be completed per household, even if students in the household attend different DCPS schools.

2014-15 FARM Applications will be available in late June 2014, and cannot be submitted prior to July 1, 2014. Applications will be available in the main office of each non-CEP DCPS school and online in various languages. To submit an application **after July 1, 2014**:

1. Submit a paper application to your youngest child's school that accepts applications (note: Schools within the CEP do not accept applications);
2. Submit an application online through a secure e-form; or
3. Mail the application to: DC Public Schools, Office of Food and Nutrition Services
   1200 First St. NE, 11th Floor, Washington, DC 20002

All DCPS students will carry their 2013-14 meal payment status with them through Sept. 30, 2014. As of Oct. 1, 2014, all students in non-CEP schools that have not submitted an application will automatically be required to pay for lunch meals.

Allergies and Dietary Accommodations

DCPS recognizes that students may have important and varied dietary needs. The "Students with Special Dietary Needs Form" found on the reverse side of this sheet allows parents to notify schools of their child's dietary needs. **Please note that this form must be filled out every school year because dietary needs change over time.**

Steps in using the Students with Special Dietary Needs Form:

1. **This form requires a licensed medical provider's signature** (except for lactose intolerances which only require a parent/guardian signature).
2. Completed forms must be turned in to your school nurse.
3. The school nurse will inform school staff of the student's needs to ensure safety at all times.
4. The schools nurse will forward the form to the Office of Food and Nutrition Services which will ensure accommodations are made for all food served through the cafeteria.

Additional information regarding food accommodations as well as the "Religious/Philosophical Dietary Accommodations Application" can be found online at: dcps.dc.gov/DCPS/Beyond+the+Classroom/Food+Services/Food+Accommodations.

For additional questions or concerns, please contact the Office of Food and Nutrition Services at: food.dcps@dc.gov, (202) 442-5112, or dcps.dc.gov/DCPS/Beyond+the+Classroom/Food+Services.

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Please turn in this form to the **nurse** at your child's school. The nurse will then inform school staff and the Office of Food & Nutrition Services of your child's needs.

Students with Special Dietary Needs Form
School Year 2014-2015

If the student has special nutritional or feeding needs, complete this form and have it signed by a recognized medical authority. If nutrition needs are indicated in an IEP, please attach a copy of the IEP.		
Student's Name:	ID:	Date of Birth:
Name of School:	Grade Level:	Teacher's Name: (if known)
Does the student have a disability? If yes, describe the major life activities affected by the disability:		
List Special Diet or Dietary Restrictions:		
Food Allergies or Intolerances:		
Foods to be Substituted:		
List foods that need changes in texture. If all foods need to be prepared in this manner, indicate "All." Use an additional sheet if necessary.		
Food requiring texture modifications	Modification (chopped, finely ground, pureed or blended, thickened liquids)	Other instructions (including special eating/feeding patterns, feeding techniques, and equipment needed)
Parent/Guardian Name:		Phone: Email:
Medical Provider Name: (physicians, physician assistants, nurse practitioners, etc.)		Phone:
Additional Contact Name:		Phone:
Additional Contact Name:		Phone:

_____ Signature of Parent or Guardian

_____ Date

_____ Signature of Medical Provider

_____ Date

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Notification of Rights under FERPA

The Family Educational Rights and Privacy Act (FERPA) affords parents and students age 18 or older ("eligible students") certain rights with respect to the student's education records. These rights are as follows:

(1) The right to inspect and review the student's education records within 45 days of the day the District of Columbia Public Schools (DCPS) receives a request for access. Parents or eligible students should submit to the school principal a written request that identifies the record(s) they wish to inspect. The school principal or other appropriate school official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

(2) The right to request amendment of the student's education records that the parent or eligible student believes are inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA. Parents or eligible students may write the school principal, clearly identify the part of the record they want changed, and specify why it should be changed. If DCPS decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

(3) The right to consent (in writing) to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. For example, FERPA authorizes disclosure without consent to school officials whom DCPS has determined to have legitimate educational interests. A school official is a person employed by DCPS as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person or company with whom DCPS has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); an official of another school system where a student seeks or intends to enroll, or where the student is already enrolled; or a parent, student or other volunteer serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

(4) The right to withhold disclosure of directory information. At its discretion, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without the consent of parents or eligible students in accordance with the provisions of District law and FERPA. Directory information includes:

A. Student Name
B. Student Address
C. Student Telephone Listing
D. Name of School Attending
E. Participation in Officially Recognized Activities and Sports
F. Weight and Height of Members of Athletic Teams
G. Diplomas and Awards Received
H. Student's Date and Place of Birth
I. Names of Schools Previously Attended
J. Dates of Attendance

Parents or eligible students may instruct DCPS to withhold any or all of the information identified above (i) by completing the "Release of Student Directory Information". Form is available at www.dcps.dc.gov/enroll or the local school, or (ii) by providing notice in writing to the Office of Data and Accountability at 1200 First St. NE, 12th Floor, Washington, DC 20002. The release or notification must be provided within 30 days of the issuance of this notice.

(5) The right to file a complaint with the U.S. Department of Education concerning alleged failures by DCPS to comply with the requirements of FERPA. The name and address of the office that administers FERPA are: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Ave. SW, Washington, DC 20202.