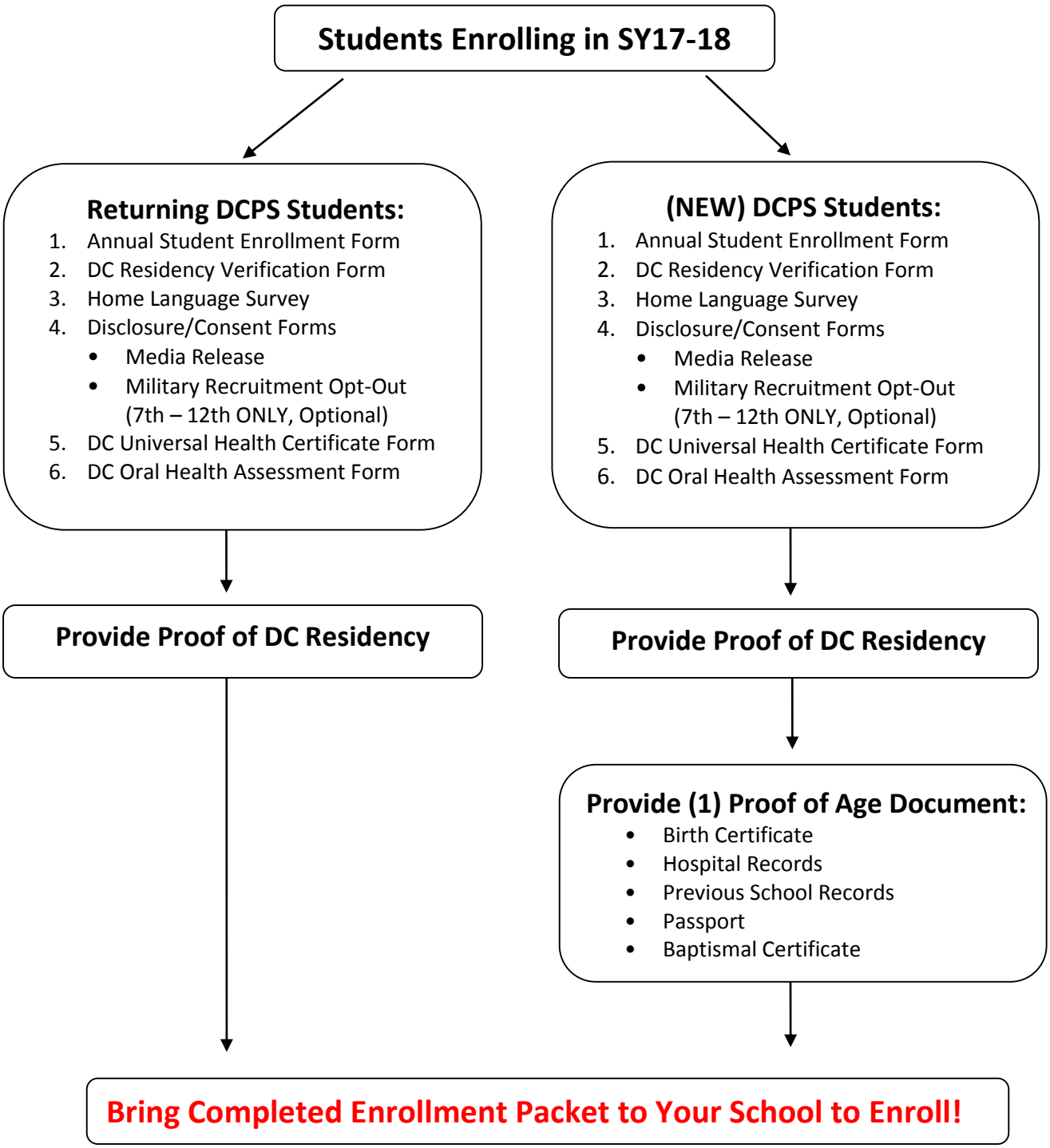
DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

How to Enroll in DCPS

Enroll for School Year 2017-2018 in 3 Easy Steps:

1) Complete the enrollment Packet.
2) Provide proof of DC residency as listed in the Residency Verification Guidelines.
3) Bring completed Enrollment Packet to your school.



1200 First Street, NE | Washington, DC 20002 | T 202. 442. 4090 | F 202. 442. 5315 | www. dcps. dc. gov

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Additional Resources:

- DC Residency Verification Guidelines
- DC Universal Health Certificate Instructions
- DCPS School Health and Immunization Requirements
- FERPA Notification
- Free and Reduced Price Meal (FARM) Application Notification
- Information on School Meals, FARM, and Allergies and Dietary Accommodations

You can locate all documents online at www.dcps.dc.gov/enroll. Translations are available in Amharic, Chinese, French, Korean, Spanish, and Vietnamese.

If you have any questions about completing your enrollment packet, please do not hesitate to contact your child's school directly or the Enrollment Team within the Office of the Chief Operating Officer at 202-478-5738.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Name: _____

ANNUAL STUDENT ENROLLMENT FORM

School Year 2017-2018

(Print all information)

STUDENT INFORMATION

Last Name	First Name	Middle Name	DCPS Student ID#

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

Race (choose one or more):
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ White
☐ Black/African American

Country of Birth (if other than US):

Date of Birth (mm/dd/yyyy) / /

Student's Gender ☐ Male ☐ Female

Phone number: ( )

Students New to DCPS

Street Address	Apt. No.

City	State	ZIP

Previous School (if not DCPS):
City, State, Zip:

Current IEP for Special Education services	☐ Yes	☐ No
Current 504 plan	☐ Yes	☐ No
Allergies *(if "yes", please complete form)*	☐ Yes	☐ No
Dietary restrictions *(if "yes", please complete form)*	☐ Yes	☐ No
Required medications *(if "yes", please complete* form)	☐ Yes	☐ No

Grade Level next school year (17-18)

PK3 PK4 K 1 2 3 4 5 6
7 8 9 10 11 12 Adult

PARENT/GUARDIAN INFORMATION

Parent/Guardian	Relationship

Street Address

City	State	Zip

Email Address	
	☐ Email opt-in ☐ Text message opt-in

Home Phone	Cell Phone	Work Phone

Other Parent/Guardian/Contact	Relationship

Street Address

City	State	Zip

Email Address	
	☐ Email opt-in ☐ Text message opt-in

Home Phone	Cell Phone	Work Phone

SIBLING INFORMATION

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Name				
Student ID#				
School				
Date of birth				

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

Name	Relationship

Street Address

City	State	Zip

Home Phone	Cell Phone	Work Phone

Name	Relationship

Street Address

City	State	Zip

Home Phone	Cell Phone	Work Phone

HOUSING STATUS (CHECK ALL THAT APPLY)

Permanent	Hotel/Motel	Shelter	Unsheltered	Doubled Up	Foster Care/CFSA	Awaiting 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. By signing below, I acknowledge my agreement with any consents or opt-ins provided in this form. Form should not be signed prior to April 1.**

_____ _____

Signature of Enrolling Parent/Guardian **Date**

Name of LEA/School

FORM 1 - DC RESIDENCY VERIFICATION FORM

Part A. Parent/Guardian/Caregiver or Adult Student Confirmation

I am the ☐ parent/guardian ☐ other primary caregiver ☐ adult student who is enrolling_____in school.
(Adult Student/Student Full Name)

I, the parent/guardian/caregiver or adult student, affirm that I reside at the following address:

Street | City, State | Zip Code

Part B. Parent/Guardian/Caregiver or Adult Student Sworn Statement of DC Residency

I understand that enrollment of the above named student in District of Columbia public schools or public charter schools, or other schools providing educational services funded by the District of Columbia, is based on my representation of bona fide DC residency, including this sworn statement of physical presence and my presentation of residency verification documentation. If this sworn statement is false, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school. Additionally, I understand that, under D.C. Code §38-312, any person who knowingly supplies false information to a public official in connection with student residency verification shall be subject to payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both a fine and imprisonment. I hereby waive my rights to confidentiality of information relative to my residence and understand that the District of Columbia will use whatever legal means it has at its disposal to verify my residence. I also agree to notify the school of any change of residence for myself or the student within three (3) school days of such change.

(Printed Name of Parent/Guardian/Caregiver or Adult Student) (Phone Number)

(Signature of Parent/Guardian/Caregiver or Adult Student) (Date)

Part C. General Residency Verification (must be completed by school official)

The person who enrolled the student or the adult student has presented the following as proof of his/her District of Columbia residency.
Each item must contain the name of the person enrolling the student or the name of the adult student and his/her DC address along with the criteria below.

(Refer to List of Acceptable Supporting Documentation Checklist on reverse side for detailed explanations.)

(1) One of the following items:
- ____ Pay stub, issued within 45-day window.
- ____ Unexpired official documentation of financial assistance.
- ____ Certified copy of DC Tax Form-D40.
- ____ Military housing orders.
- ____ Embassy letter.

(2) Two of the following items with matching names and addresses.
- ____ Unexpired DC motor vehicle registration.
- ____ Unexpired DC driver's license or non-driver ID.
- ____ Unexpired lease with proof of payment.
- ____ Utility bill with proof of payment.

(3) If one of the following applies, no signature is required in Part B above.
- ____ There is evidence that the student is homeless and the homeless liaison has provided homeless documentation.
- ____ Child is a ward of the District of Columbia.

(4) Use only if none of the previous options apply.
- ____ The person enrolling the student or the adult student has consented to a home visit. The visit is complete and the **Home Visitation Residency Verification Form** and **Home Visitation Consent Form have been completed** to confirm residency.

I certify, under the penalties of perjury, that I have personally reviewed all the documents presented and affirm that the information represented above is true to the best of my knowledge, information, and belief. I also affirm that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies including but not limited to the DC Office of the Inspector General, DC Office of the Attorney General, etc. upon request.

School Official (Print) | School Official (Signature) | Date

List of Acceptable Supporting Documentation Checklist

Section 1 (One is needed from this list to verify residency.)

- ○ **Pay stub:** Issued within the forty-five (45) day-window immediately preceding the school's review of residency documentation, that contains the name of person enrolling the student or the name of the adult student, shows his/her current DC home address, and shows withholding of DC personal income tax for the current tax year.
- ○ **Unexpired official documentation of financial assistance from the Government of the District of Columbia:** Issued to the person enrolling the student or the adult student within the past twelve (12) months and be current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs.
- ○ **Certified copy of Form D40:** Certified by the DC Office of Tax and Revenue, with the name of person enrolling the student or the name of the adult student as evidence of payment of DC taxes for the current or most recent tax year.
- ○ **Military housing orders:** Showing the name of the person enrolling the student or the name of the adult student, and their residency or home address in DC, including but not limited to a DEERS statement or other official communication on military letterhead.
- ○ **Embassy letter:** Issued within the past twelve (12) months showing the name of the person enrolling the student or the name of the adult student, indicating that the caregiver and the dependent student or the adult student currently live on embassy property in the District of Columbia or will reside on DC property confirmed by the embassy during the relevant school year, and an official embassy seal.

Section 2 (Two are needed from this list to verify residency. The address and name on each of the items must be the same.)

- ○ Unexpired **DC motor vehicle registration** showing the name of the person enrolling the student or the name of the adult student and his/her current DC home address.
- ○ Unexpired **lease or rental agreement with proof of payment of rent**, in the name of the person enrolling the student or the name of the adult student, for a period within two (2) months immediately preceding the school's review of residency documentation, for the current DC address at which the student actually resides.
- ○ Unexpired **DC motor vehicle operator's permit** or official government issued non-driver identification in the name of the person enrolling the student or the name of the adult student showing his/her current DC home address.
- ○ **Utility bill** (***only gas, electric, and water bills are acceptable***) **with proof of payment of a bill**, from a period within the two (2) months immediately preceding the school's review of residency documentation, listing the name of the person enrolling the student or the name of the adult student and his/her current DC home address,.

Section 3 (If one of these applies, no signature is required in Part B.)

- ○ **Homeless:** There is evidence that the student is homeless and the school's homeless liaison has provided the appropriate homeless documentation.
- ○ **Ward of the District of Columbia:** Proof that child is a ward of the District of Columbia, in the form of a court order or official documentation from DC Child and Family Services Agency.

Penalty for False Information:

Any person, including any District of Columbia public school or public charter school official, who knowingly supplies false information to a public official in connection with student residency verification shall be subject to charges of tuition retroactively, and payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both fine and imprisonment, pursuant to the District of Columbia Nonresident Tuition Act, approved September 8, 1960 and amended by the District of Columbia Public Schools and Public Charter School Student Residency Fraud Prevention Amendment Act of 2012 (D.C. Code §38-312). The case of any such person may be referred by the Office of the State Superintendent of Education to the Office of the Attorney General.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Consent and Release for Students to be Filmed/ Photographed/ Interviewed and for Use of Image/Voice/School Work

I, _____ hereby grant to District of Columbia Public Schools ("DCPS"), and its employees and agents, 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,_____, 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 without my express written permission.

I further grant District of Columbia Public Schools (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 its employees and agents, as well as the District of Columbia Government, 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. This consent and release form is valid through the end of the summer school session following the school year during which it is signed.

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**

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

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)	**Date**

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/non-discrimination.*

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Home Language Survey (HLS) Form

To help us ensure that important opportunities to receive English Learner services are offered to students who need them, the law requires us to ask questions about the students' language backgrounds. Your answers below will tell us if your student's proficiency in English should be evaluated.

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 speak/communicate at home in a language other than English?
☐ No ☐ Yes _____ (specify language)
3. In what language do you prefer to receive information from the school?
_____ (specify language)
4. What is your relationship to the child?
☐ Father ☐ Mother ☐ Guardian ☐ Other (specify) _____

Español (Spanish)

Para ayudarnos a asegurar que las oportunidades para recibir servicios de Inglés como Segundo Idioma se le ofrezcan a los/as estudiantes que lo necesitan, la ley requiere que le preguntemos sobre el idioma materno del estudiante. Su respuesta nos dejará saber si el dominio del idioma Inglés de su estudiante debe ser evaluado.

1. ¿Se habla otro idioma en casa que no sea el inglés?
☐ No ☐ Si _____ (especifique el idioma)
2. ¿En casa, habla o se comunica el/la estudiante en un idioma no sea el inglés?
☐ No ☐ Si _____ (especifique el idioma)
3. ¿En qué idioma prefiere recibir la información de la escuela?
_____ (especifique el idioma)
4. ¿Cuál es su parentesco con el/la estudiante?
☐ Padre ☐ Madre ☐ Encargado ☐ Otro (especifique)_____

አንጊሊዘኛ (Amharic)

ለእንጊሊዘኛ ቋንቋ ተማሪዎች የሚያስፈልጓቸው አገልግሎቶች፣ ጠቃሚ መረጃዎች የሚደርሳቸው መሆኑን ዕውን ለማድረግ እንዲረዳን፣ስለተማሪው የቋንቋ መደብ ጀርባ ሁኔታዎች እንድንጠይቅ ህጉ ያስገድዳል። ከዚህ በታች ለቀረቡት ጥያቄዎች የሚሰጧቸው ምላሾች፣ተማሪ ልጅዎ የእንጊሊዘኛ ቋንቋ የቅልጥፍና ደረጃው መገምገም ይገባው እንደሆነ ሊነግረን ይችላል።

1. በቤት ውስጥ ከእንጊሊዘኛ ቋንቋ ውጪ ሌላ ቋንቋ ይነገራል?
☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
2. ልጅዎ በቤት ውስጥ ከእንጊሊዘኛ ውጪ በሌላ ቋንቋ ይናገራል/ይግባባል ወይ?
☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
3. ከትምህርት ቤት የሚደርስዎት መረጃዎች በየትኛው ቋንቋ ቢላክልዎት ይመርጣሉ?
_____ (ቋንቋውን ይጥቀሱ)
4. ለልጁ ያለዎት ዝምድና ምንድን ነው?
☐ አባት ☐ እናት ☐ አሳዳጊ ☐ ሌላ (ይጠቀስ) _____

Français (French)

Afin que nous nous assurions que les opportunités importantes et les services dont peuvent bénéficier les apprenants en anglais soient offerts aux élèves qui en ont besoin; nous sommes tenus par la loi de vous poser des questions concernant les langues que vous parlez. Vos réponses ci-dessous nous permettrons de savoir si le niveau d'anglais de votre enfant doit être évalué.

1. Est-ce qu'une autre langue que l'anglais est parlée à la maison?
☐ Non ☐ Oui _____ (Spécifiez la langue)
2. Est-ce que votre enfant communiquer dans une autre langue que l'anglais à la maison?
☐ Non ☐ Oui _____ (Spécifiez la langue)
3. En quelle langue préférez-vous recevoir des informations de l'école?
_____ (Spécifiez la langue)
4. Quel est votre lien de parenté avec l'enfant?
☐ Père ☐ Mère ☐ Tuteur ☐ Autre (Veuillez spécifier) _____

中文(Chinese)

为了帮助我们确保为向有需要的学生提供接受英语学习生服务的重要机会，法律要求我们询问了解学生的语言背景。 您对下列问题的回答将表明您的孩子是否应该接受英语熟练程度的评估。

1.在家里是否说除了英语之外的一种语言?
☐否 ☐是 _____（请说明语言）
2.您的孩子在家是否说除了英语之外的一种语言或以这种语言进行沟通?
☐否 ☐是 _____（请说明语言）
3.您喜欢以哪一种语言从学校收到信息?
_____（请说明语言）
4.您与孩子的关系是什么?
☐父亲 ☐母亲 ☐监护人 ☐其他（请说明） _____

Tiếng Việt (Vietnamese)

Để giúp chúng tôi chắc chắn rằng các cơ hội và dịch vụ quan trọng dành cho người học tiếng Anh sẽ được cung cấp cho các học sinh cần đến, luật lệ đòi hỏi chúng tôi phải hỏi các câu hỏi về ngôn ngữ mẹ đẻ của học sinh. Các câu trả lời của quý vị dưới đây sẽ cho chúng tôi biết nếu học sinh cần được lượng định trình độ Anh ngữ.

1. Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?
☐ Không ☐ Có _____ (ghi rõ ngôn ngữ)
2. Con em có nói hoặc giao tiếp một ngôn ngữ nào khác hơn tiếng Anh ở nhà hay không?
☐ Không ☐ Có _____ (ghi rõ ngôn ngữ)
3. Quý vị muốn nhận được thông tin từ trường học bằng ngôn ngữ nào?
_____ (ghi rõ ngôn ngữ)
4. Xin cho biết liên hệ của quý vị đối với đứa trẻ?
☐ Cha ☐ Mẹ ☐ Người Giám Hộ ☐ Liên hệ khác (xin ghi rõ) _____

_____ _____

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

MY SCHOOL DC
Learn • Apply • Enroll
MySchoolDC.org

ENROLLMENT FORM
2017-18 School Year

Parents/Guardians: Please complete this form to confirm your child's enrollment in a My School DC school.

Student Information ***You must fill out one form for each child you are enrolling.**

First Name:	*MI:*	*Application Tracking #:*
Last Name:	*Date of Birth:* ____/____/____ MONTH DAY YEAR	
Current School (2016-17):	*Current Grade (2016-17):*	
Enrolling School (2017-18):	*Enrolling Grade (2017-18):*	

Parent/Guardian Information ***Should be the person completing the form and confirming residency.**

First Name:	*Last Name:*	
Address:		
City:	*State:*	*Zip:*

Records Release ***Please check the *required* box below so that the enrolling school can request your child's records.**

☐ I hereby authorize the enrolling school to request records from the current school for the student above. I also hereby authorize the enrolling school to request records from any other previous schools that the student above has attended. I understand that the enrolling school will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation ***Please read and check each box below to confirm your enrollment for 2017-18.***

☐ I understand that by submitting this form, I am confirming the enrollment of the student above in the enrolling school for 2017-18.

☐ I understand that I cannot maintain enrollment at more than one school for 2017-18.

☐ I understand that once this form is submitted, I will give up my space at my current school for next school year (2017-18) and my current school will be notified that my space may be awarded to another family.

☐ I understand that if I enroll as a result of receiving a waitlist offer from this school that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Parent/Guardian Signature:	Date: ____/____/____ MONTH DAY YEAR

THIS SECTION IS TO BE COMPLETED BY STAFF AT THE ENROLLING SCHOOL

Date Received: ____/____/_____ **Time Received: _____** **Printed Staff Name: _____** **Staff Signature: _____**	**School Seal (if applicable):**

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

RESIDENCY VERIFICATION GUIDELINES

LIST OF ACCEPTABLE RESIDENCY DOCUMENTS
All documents must be in its original format and UNEXPIRED

- Parents/guardians are required to verify DC residency each year, upon enrollment of the student.
- Parents/guardians may present one document from List A or two documents from List B in order to verify DC residency.
- Parents/guardians must provide original documents to school officials, and documents must be in the name of the enrolling parent/guardian. **School officials are required by DC law to photocopy residency documents for audit purposes.**
- Parents/guardians must also complete the DC Residency Verification form each year, upon enrollment. This document must be signed by the same enrolling parent/guardian whose name appears on the residency documents.

List A **One** of the following indicating name and address of enrolling parent/guardian.	List B **Two** of the following indicating name and address of the enrolling parent/guardian. The name and address must the same on **both** documents.
A pay stub, issued within **45 days** prior to school's review of residency documentation, showing DC address and DC tax withholding	Unexpired DC motor vehicle registration
Supplemental Security Income annual benefits notification	
Verification letter **and** Military Housing orders; **or** DEERS Statement	Unexpired DC motor vehicle operator's permit **or** official non-driver identification
An embassy letter indicating embassy sponsored housing in DC with embassy seal affixed	
Unexpired official documentation of financial assistance from the DC Government including TANF, Medicaid, SCHIP, SSI, housing assistance or other DC Government Programs	Unexpired lease with proof of payment within 2 months preceding school's review of residency documents
A copy of D-40 form certified by the DC office of Tax & Revenue form	
Proof that the child is a ward of the District of Columbia, in the form of a Court Order or notification from the DC Child and Family Services Agency	Utility bill (only gas, electric and water bills are acceptable) **with** receipt of payment within 60 days of school's review of residency documentation

For questions and guidance, please contact the Enrollment Team at enroll@dc.gov or at 202-478-5738.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Health Requirements, School Year 2017-2018

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 and Oral Health Assessments for all students enrolling in all 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 exam 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. Need help finding a doctor? Contact your health plan's Member Services at the number printed on the back of your health insurance card.)
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 may be excluded from classes.	Please schedule a visit with your child's physician as soon as possible 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)
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's nurse or online at: http://dcps.dc.gov/service/medication-and-treatment-school.	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 as soon as possible to make sure everyone is ready to meet your child's health needs.	Whenever possible, please administer medications at home. If your child needs to take medication or requires medical treatment during school hours, please have your child's medical provider complete the appropriate forms (Medication and Treatment Authorization Form, Asthma Action Plan and/or the Action Plan for Anaphylaxis). If students are allowed to self-administer medications for asthma, anaphylaxis, or diabetes while at school, this must be indicated on the appropriate medication action plan signed by the student's parent or guardian and physician. If you have any questions about which form is needed for your child, please speak with your school's nurse. Forms should be submitted to your school's nurse along with appropriately labeled medication (if applicable). If your child needs a dietary accommodation, your provider should also complete the Dietary Accommodations Form. To ensure that your child's health needs are met while at school, or to locate any of the forms described above, please refer to *Meeting Your Child's Medication and Treatment Needs at School,* for detailed information. This can be found at http://dcps.dc.gov/service/medication-and-treatment-school.

If you have any questions, please feel free to contact healthservices.dcps@dc.gov or 202-719-6555. You can find copies of these forms on the DCPS website.

District of Columbia Immunization Requirements[1]
School Year 2017 – 2018

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 (Men ACWY) [4]
- **2 or 3** Human Papillomavirus Vaccine (HPV) [5]

[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.

[4] Quadrivalent Meningococcal (MenACWY). Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

[5] Two (2) doses if student receives first dose between 9 and 14 years of age with doses separated by 6-12 months. Three (3) doses if student starts series on or after 15 years of age.

Rev 02-17

District of Columbia Immunization Requirements[1]
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DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form replaces all physical examination forms dated before April 1, 2015. The District of Columbia Universal Health Certificate (DC UHC) is required annually for children enrolled in Child Development Facilities, Head Start, and DC public, public charter, private and parochial schools.
Exception: The DC UHC does not replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DC UHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) recommendations 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 your 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. In addition, please provide the name of the insurance company and the child's identification number in the space provided. Write the name of the child's licensed health practitioner/primary care provider (doctor or nurse practitioner). If your child does not have a particular licensed health practitioner who provides care, 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 licensed health practitioner). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination conducted by a physician, or nurse practitioner (some nurse practitioners also use the Advanced Practice Registered Nurse or APRN credential), as per the AAP recommendations, and DC Official Code § 38-602(a). The date entered here must indicate the actual 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 (3) 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 two (2) years of age or older, the BMI has to be calculated and recorded inclusive of percentile. BMI is a measurement calculated from a child's weight and height.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is **required for all children under six (6) years of age**. Also, in accordance with AAP recommendations, anemia screening is recommended for menstruating girls. Please record the blood level and indicate which test was performed by encircling HGB, HCT or both.
- **Vision and Hearing Screens:** Children should begin receiving regular objective vision screens at age three (3), and objective hearing screens at age four (4). If an objective screen cannot be completed, but there is cause for concern, provide an explanation and resolution in Part 2, Section A.
- **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 (Under Rx) for the concern. If there are NO/NONE "HEALTH CONCERNS" check the **"NO" or "NONE"** box in each health screening area.
- **SPECIAL NOTE:** "Dental Exam" – 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 dental home. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that children begin visiting the dentist within six (6) months of the eruption of the first tooth or by 12 months of age, and every six (6) months thereafter. For children under three (3) years of age, a licensed health practitioner may provide fluoride varnish applications if a dental home has not yet been established. Fluoride varnish applications are not required for entrance to child care or school.
- **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 Medication Plan or Licensed Practitioner's Medication Authorization Order and attach it to the DC UHC.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing: TUBERCULOSIS (TB) RISK ASSESSMENT: Perform a risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the* most recent *AAP RED BOOK, and* in accordance with DC Official Code § 38-602 (c) (1) *Examination Requirements* and *DCMR 29-325.3 (g) Public Welfare, Child Development Centers*. Current DC regulations require that all children attending a child development facility (CDF) or school undergo a comprehensive annual physical examination inclusive of a tuberculosis exposure risk assessment, which is documented on the DC UHC. A tuberculin skin test (TST) should only be conducted upon recognition of **high risk factors** for exposure to tuberculosis**.** For children who are assessed as **HIGH RISK OF EXPOSURE,** please conduct the TST and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and if the child is treated mark the "treated" box. **All positive TSTs of children younger than five (5) years of age must be reported to the DC T.B. Control Program on 202-698-4040.** If the child is assessed as having a low risk of exposure, mark **"low"** in the box**. Please note that universal tuberculin skin testing of children entering CDFs and schools is neither recommended nor required.**
• **LEAD EXPOSURE RISKS: Every child less than six years of age must be tested twice for lead, regardless of perceived exposure risk. P**lease document both the "Date" and "Result" of the most recent lead test on the DC UHC. Please indicate if "Pending." "Pending" results will be **valid for two months from the date of testing** and will not cause a child to be excluded from school-related activities or programs. The **'***Certificate of Testing for Lead Poisoning'* may also serve as test documentation and is available on the DDOE website: http://ddoe.dc.gov/publication/lead-screening-guidelines. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead and Healthy Housing Program. For detailed instructions, call 202-654-6036/202-535-2624**. **Providers may fax results to secure fax: 202-535-2607.** Please include the name, address, and phone numbers of the licensed health practitioner and parent/guardian.
Part 4: Required Licensed Health Practitioner's (physician or nurse practitioner) Certification and Signature: Providers remember to print your name and use the office/clinic stamp. Licensed health practitioner please 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; and the child has received age-appropriate screenings (in accordance with AAP recommendations 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 licensed health practitioner 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.**
Access health insurance programs at **https://dchealthlink.com**. You may contact the School Nurse through the main office at your child's school.

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 the date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature, address, phone number and date. Vaccine 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.

Students shall be immunized in accordance to D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 and the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Requirements – For immunization requirements for District of Columbia School and Child Care Facility attendance, consult the Department of Health Immunization Program website at https://immunization.doh.dc.gov/irswebapp/home.jsp.

Immunization requirements are subject to change.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pneumovax	PPSV or PPV23	Vaqta	Hep A
Adacel	Tdap	Fluarix	Flu (IIV)	Infanrix	DTaP	Prevnar	PCV or PCV7 or PCV13	Varivax	Varicella
Afluria	Flu (IIV)	FluLaval	Flu (IIV)	Kinrix	DTaP + IPV	ProQuad	MMR + Varicella		
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	Recombivax	Hep B		
Cervarix	HPV2	Fluvirin	Flu (IIV)	Menomune	MPSV or MPSV4	Rotarix	Rotavirus (RV1)		
Comvax	Hep B + Hib	Fluzone	Flu (IIV)	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Tripedia	DTaP		
Decavac	Td	Havrix	Hep A	Pentacel	DTaP + Hib + IPV	Twinrix	Hep A + Hep B		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviation	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenza* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

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, address, phone number 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, address, phone number or stamp 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* *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 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.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: _____ **DOB:** _____

SCHOOL: _____ **SOC. SEC. #**_____ **Grade:** _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained Certified DCPS Personnel to administer prescribed medication as directed by the physician to _____.
STUDENT'S NAME

I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required.

This medication is a ☐ new or ☐ renewal prescription. If new prescription, enter date and time the first dose was given at home.

Date: _____ Time: _____ A.M/P.M.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP

_____ _____
PLEASE PRINT NAME DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this action. ☐ Original ☐ Renewal ☐ Change

NAME OF STUDENT: _____ DOB::_____

ADDRESS: _____ TEL. NO.:_____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSE::_____

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____

_____

EXPECTED DURATION OF ADMINISTRATION: _____

CAN REACTION BE EXPECTED? ☐ Yes ☐ No If yes, please describe: _____

If any change, please advise in writing immediately.

_____ _____
PHYSICIAN'S SIGNATURE ADDRESS

_____ _____ _____
PLEASE PRINT NAME TELEPHONE NO. DATE

_____ _____
SCHOOL NURSE DCPS TRAINED STAFF

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are scheduled during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. No medication will be administered without the parent's/guardian' signed consent and the physician's written medication authorization order. This will be kept on file in the Student's Health Record. The parent/guardian is responsible for obtaining the required information from the physician.

2. A separate parent/guardian consent form and physician's medication authorization order must be on file for each medication a student is to receive at school.

3. The medication must be properly labeled by the pharmacist. The label must include: a.) Name of student's name, b.) Name of medication, c.) Date, d.) Dosage and time of administration, and e.) Directions for administration.

4. The first day's dosage of any new medication must be given at home.

5. All medications must be brought to school be the parent/guardian and given to authorized personnel.

6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.

7. All medication kept in school will be stored in a secure area accessible only to authorized administering personnel. (Such storage will be at the risk of the parent/guardian). The school nurse nor District of Columbia Public Schools (DCPS) personnel will assume any responsible for possible loss of students' medication.

8. One week after expiration of the physician's order, the unused portion of the medication must be collected by the parent/guardian or it will be destroyed.

9. DCPS personnel nor the school nurse will assume any responsibility for non-medically prescribed medication or medication self-administered by the student.

10. Parents/guardians must let DCPS and the school nurse know in writing if a student is Lactose-intolerant.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

NAME: _____ **DOB:** _____

SCHOOL: _____ **SSN#:** _____

TEACHER: _____ **GRADE:** _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse (RN, LPN, Nurse's Aide, Technician) or a trained DCPS employee to perform _____
SPECIFIC MEDICAL PROCEDURE/TREATMENT

on my child_____ **as prescribed by the physician below.**

I have read the information on the reverse side of this form and agree to assume responsibilities as required.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO CHILD

_____ _____
PLEASE PRINT DATE

PART II: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION ORDER

Physician: Please complete and sign this action.

NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____

DIAGNOSIS: _____

SPECIFIC PROCEDURE/TREATMENT: _____

TO BEGIN ON: _____ **AND END ON**_____
DATE DATE

REASON FOR PROCEDURE/TREATMENT: _____

INSTRUCTIONS: _____

PRECAUTIONS: _____

POSSIBLE ADVERSE REACTIONS: _____

_____ _____
PHYSICIAN'S SIGNATURE PLEASE PRINT

_____ _____
ADDRESS PHONE

_____
SCHOOL NURSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program

AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT

Dear Parent/Guardian and Physician:

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parents/guardians must present to the principal and school nurse a signed consent and physician's written authorization for the procedure/treatment. The physician's authorization and parent's consent will be maintained in the Student Health Record.

2. The parent/guardian's signed consent and physician's authorization must be in place before the student receives the specific medical procedure/treatment.

3. The physician's authorization must include: the student's name, date of birth, address, telephone number, diagnosis, name of procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.

4. The parent/guardian must meet at school with the principal, school nurse and other authorized school personnel to initiate the specific medical procedure/treatment.

5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and supplies that are required must remain in the school if possible.

6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each semester and summer school if the student continues to need the procedure/treatment.

7. If any adjustments (i.e., technique, frequency, medications) are made, a new Physician Authorization, and Parental Consent Form will be required.

8. All equipment and supplies kept in the school will be stored in a secured area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Children's National Medical Center School Health Program personnel (CNMC School Nurses) and District of Columbia Public School personnel (DCPS trained persons) assume no responsibility for possible loss of or damage to equipment and supplies.

9. One week after expiration of the physician's order, the equipment and unused portions of the supplies must be collected by the parent/guardian, or they will be discarded.

10. CSS personnel and DCPS personnel assume no responsibility for non-medically prescribed procedures/treatments or those self-administered by the student.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

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. Upon request, DCPS discloses education records without consent to officials of another school or school district in which a student seeks or intends to enroll, or is already enrolled if the disclosure is for purposes of the student's enrollment or transfer.

(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 attached "Release of Student Directory Information" Form also available at www.dcps.dc.gov/enroll or your local school).

(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.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Release of Student Directory Information

The Family Educational Rights and Privacy Act (FERPA) is a federal law that requires DCPS, with certain exceptions, to get your permission before disclosing personally identifiable information from education records. However, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without your consent. The primary purpose of directory information disclosure is to allow DCPS to include this type of information in certain school publications such as pamphlets for drama productions, graduation programs, honor rolls or sports team activity sheets for football, basketball, etc. Directory information can also be disclosed to outside organizations such as federal and state agencies offering jobs and educational benefits, media sources, and companies that make class rings and publish yearbooks.

The information listed below has been designated as directory information under District of Columbia law and FERPA, and may therefore be released at the discretion of DCPS. You have the right to instruct DCPS that it may not release any or all of this information without obtaining your prior written consent by completing this form. Your decision on this form will be valid for the remainder of the current school year. **A new Release of Student Directory Information form must be completed each School Year.**

Please place a check mark on the line beside any directory information items listed below that you do not want DCPS to disclose without your consent, if any.

_____Student Name
_____Student Telephone Listing
_____Name of School Attending
_____Participation in Officially Recognized Activities and Sports
_____Weight and Height of Members of Athletic Team
_____Diplomas and Awards Received
_____Student Address
_____Student's Date and Place of Birth
_____Names of Schools Previously Attended
_____Dates of Attendance

By signing below I am giving written notification to DCPS that it may not disclose the directory information items I have placed a check mark beside above unless I give prior written consent. I understand that such information may still be disclosed by DCPS if disclosure is otherwise permissible under FERPA.

_____
Student Name (please print)

_____
Parent/Guardian Name (please print)

_____ _____
Signature of Parent/Guardian or Student (if at least 18 years old) Date

***If this form is not returned by September 15, it will be assumed that the above information may be designated as directory information for the remainder of the school year. ***

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Parents Right-To-Know Notification

Dear Parent:

In accordance with the Every Student Succeeds Act of 2015, the District of Columbia Public Schools (DCPS) is notifying you that you have the right to request information regarding the professional qualifications of your child's classroom teachers. DCPS is happy to provide this information to you. At any time, you may ask for the following information:

- Whether the teacher has met District of Columbia qualification and licensing criteria for the grade levels and subject areas in which the teacher provides instruction;
- Whether the teacher is teaching under emergency or other provisional status through which District of Columbia qualification or licensing criteria have been waived; and
- Whether the teacher is teaching in the field of discipline of the teacher's certification.

You may also ask, at any time, whether your child is being provided services by paraprofessionals and, if so, their qualifications.

Please direct teacher and paraprofessional qualification requests, and any other questions related to this notice to DC Public Schools at dcps.hrdataandcompliance@dc.gov or fax (202) 535-2483.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of the General Counsel

Notification of Rights Under the
Protection of Pupil Rights Amendment (PPRA)

This notice informs parents/guardians and eligible students (emancipated minors or those 18 or older) of their rights regarding the conduct of surveys, the collection and use of information for marketing purposes, and the conduct of certain physical exams. These rights are spelled out in the *Protection of Pupil Rights Amendment* (20 U.S.C. § 1232h; 34 CFR Part 98). The law and regulations require educational institutions, such as the District of Columbia Public Schools (DCPS) to notify parents and eligible students of their right to—

1. *Consent* before students are required to submit to a survey that concerns one or more of the following protected areas ("protected information survey") if the survey is funded in whole or in part by a program of the U.S. Department of Education (USDE):

    - Political affiliations or beliefs of the student or student's parent;
    - Mental or psychological problems of the student or student's family;
    - Sexual behavior or attitudes;
    - Illegal, antisocial, self-incriminating, or demeaning behavior;
    - Critical appraisals of others with whom respondents have close family relationships;
    - Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
    - Religious practices, affiliations, or beliefs of the student or parents; and
    - Income, other than as required by law to determine program eligibility.

2. *Receive notice and an opportunity to opt a student out of*—

    - Any other protected information survey, regardless of funding;
    - Any nonemergency, invasive physical exam or screening required as a condition of attendance administered by the school or its agent and not necessary to protect the immediate health and safety of a student, except for hearing, vision, or scoliosis screening, or any physical exam or screening permitted or required under state law; and
    - Any activities involving collection, disclosure, or use of personal information collected from students for marketing or to sell or otherwise distribute the information to others. (This does not apply to the collection, disclosure, or use of personal information collected from students for the exclusive purpose of developing, evaluating, or providing educational products or services for, or to, students or educational institutions.)

3. *Receive notice* of a parent's right to inspect, upon request and before administration or usage of—

    - Protected information surveys of students and surveys created by a third party;
    - Instruments used to collect personal information from students for any of the above marketing, sales, or other distribution purposes; and
    - Instructional material used as part of the educational curriculum.

DCPS has developed and adopted policies regarding these rights, as well as arrangements to protect student privacy in the administration of protected surveys and the collection, disclosure, or use of personal information for marketing, sales, or other distribution purposes. In addition, DCPS provides public access to its Survey Calendar, which notifies parents and eligible students, at the beginning of each school year and on a continuing basis, of the specific or approximate dates of the following activities (along with an opportunity to opt a student out of participating in the activity)—

- Collection, disclosure, or use of personal information for marketing, sales, or other distribution;
- Administration of any protected information survey not funded in whole or in part by USDE; and
- Any nonemergency, invasive physical examination or screening as defined above.

The DCPS policies related to PPRA rights, as well as the Survey Calendar, can be accessed by visiting the following website: http://dcps.dc.gov/page/conduct-research-or-obtain-confidential-data. In addition, parents/guardians and eligible students may also contact their neighborhood school for DCPS policies related to PPRA rights and the Survey Calendar.

Parents/guardians and eligible students who believe their rights have been violated may file a complaint with the—

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-4605