DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Student Enrollment Checklist

Welcome to School Year 2016-2017!

- All documents can be located online at http://dcps.dc.gov/enroll. Translations are available in Amharic, Chinese, French, Korean, Spanish, and Vietnamese.
- If the information has changed or is incorrect, please make changes directly on the form and review with your school's registrar.

If you have any questions about completing your enrollment packet, please do not hesitate to contact your child's school directly or the DCPS Student Enrollment Team at enroll@dc.gov or (202) 478-5738.

Returning DCPS Students	☐ Annual Student Enrollment Form ☐ Home Language Survey ☐ Media Release ☐ Military Recruitment Opt-Out (grades 7 - 12 only) ☐ DC Universal Health Certificate Form ☐ DC Oral Health Assessment Form
NEW DCPS Students	All of the forms for returning DCPS students and one proof of age document: ☐ Birth Certificate ☐ Hospital Records ☐ Previous School Records ☐ Passport ☐ Baptismal Certificate
Additional Forms	☐ DC Residency Verification Guidelines ☐ DC Universal Health Certificate Instructions ☐ DCPS School Health and Immunization Requirements ☐ Dietary Accommodation Forms ☐ Free and Reduced Price Meal (FARM) Application Notification ☐ Medication and Treatment Authorization Forms ☐ Notification of Protection of Pupil Rights Amendment (PPRA) Policy ☐ Notification of Rights under FERPA ☐ Parent Right to Know Notification ☐ Release of Student Directory Information

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Name: _____

ANNUAL STUDENT ENROLLMENT FORM

School Year 2016-2017

(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

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

Street Address	Apt. No.

City	State	ZIP

Grade Level next school year (16-17)

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**

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

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 ☐ አለ _____ (ቋንቋውን ይጥቀሱ)
2. ልጅዎ ከእንግሊዘኛ ሌላ የሚነጋገርብት ሌላ ቋንቋ አለ?
   ☐ የለም ☐ አለ _____ (ቋንቋውን ይጥቀሱ)
3. ለልጁ 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 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

School Health Requirements, School Year 2016-2017

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 202-576-7130.
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.	Whenever possible, please administer medications at home. If your child needs to take medication or requires medical treatment during school hours, you must provide the appropriate forms, completed by your child's medical provider (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, you must submit the Dietary Accommodations form, completed by your child's medical provider. 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 contact Diana Bruce, DCPS Director of Health and Wellness: 202-442-5103 or Diana.Bruce@dc.gov.

1200 First Street, NE | Washington, DC 20002 | T 202.478-5738 | F 202.442.5024 | www.dcps.dc.gov

District of Columbia Immunization Requirements[1]
School Year 2016 – 2017

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)

[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.

District of Columbia Immunization Requirements[1]
School Year 2016 – 2017

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)

[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 02-16

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.

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
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

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Parents Right-To-Know Notification

April 2016

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

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. ***