IDEA
PUBLIC CHARTER SCHOOL

Parent Guardian Checklist

Please use this checklist to keep track of the documents you must turn in for SY 2021-2022 enrollment at IDEA Public Charter School.

- ❑ Google enrollment form (completed online)
- ❑ DC Residency Verification form ("DCRV")
- ❑ Proof of DC residency (see reverse side)
  - one item from the yellow section OR
  - two items from the green section
- ❑ Copy of guardian's DC-issued identification card (new scholars only)
- ❑ Copy of scholar's birth certificate (new scholars only)
- ❑ Health forms - physical, dental, & immunization record
- ❑ 8th grade report card (for rising 9th grade scholars)
- ❑ Final '20-'21 transcript (for 10th, 11th, & 12th grade scholars)

Proving Residency thru Government Assistance or Your 2020 Taxes

If you are currently experiencing homelessness, if the student is a ward of the District, or if the family participates in a District public benefits program, such as Medicaid, Supplementation Nutrition Assistance Program (SNAP), or Temporary Assistance for Needy Families (TANF) – IDEA may already have your information. Check with the staff in the main office at (202) 399-4750.

Re-enrolling families/students who paid 2020 taxes in DC can also verify residency using the Office of Tax and Revenue (OTR) residency verification process. The student's Social Security number is required. Parents/Guardians can log in to the system at ossedctax.com. If you are successful, your verification will then be available for IDEA staff to confirm. Please call to discuss using the OTR process.

IDEA Enrollment Form SY 2021-2022

* Required

1. Email *

New Families: My School DC Acknowledgement

DC & My School DC are not using the seat acceptance form this year. The statement below is required as a replacement for that form.

2. By accepting a space at IDEA Public Charter School, I acknowledge that I am giving up my scholar's seat at our current school, that I am forgoing feeder rights to schools related to my scholar's current school, and that my scholar will be removed from the waitlists of schools that we ranked lower than IDEA Public Charter School on our My School DC application. My printed name below serves as my signature and acknowledgement. *

Scholar Information

All the necessary information about your scholar

3. Scholar's Last Name *

4. Scholar's First Name *

5. Middle Name

6. Expected Grade for SY 2021-2022 *

Mark only one oval.

- ( ) 9th
- ( ) 10th
- ( ) 11th
- ( ) 12th

7. Country of Birth *

8. Date of Birth *

Example: January 7, 2019

9. Scholar's Gender *

Mark only one oval.

- ( ) Female
- ( ) Male
- ( ) Non-binary
- ( ) Prefer not to say
- ( ) Other:

10. Primary contact number to be used in school calling systems. (There will be room below for other phone numbers.) *

11. Does your scholar LACK (not have) a fixed, regular and adequate nighttime residence? *

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) Prefer not to say

12. If so, does the scholar live under any of these conditions? (Please skip this question if your answer above was "no.")

Mark only one oval.

- ( ) In a shelter (family, youth or domestic violence shelter, transitional living program, emergency shelter/hotel)
- ( ) In a hotel/motel (family or non-government agency is paying for short-term stay)
- ( ) Unsheltered (in a car, on a campground, on the street, abandoned)
- ( ) With friends/family because the scholar is migratory or an unaccompanied minor (guardian not present)

13. Home Street Address *

14. City *

Mark only one oval.

- ( ) Washington, DC
- ( ) Other:

15. State *

Mark only one oval.

- ( ) District of Columbia
- ( ) Other:

16. Zip *

17. Home Language *

Mark only one oval.

- ( ) English
- ( ) Spanish
- ( ) Other:

18. Scholar's Ethnicity Designation *

Mark only one oval.

- ( ) Hispanic/Latinx
- ( ) Non-Hispanic/Latinx

19. Scholar's Race *

Mark only one oval.

- ( ) Black/African American/African (BL)
- ( ) Native American/Alaska Native (AM)
- ( ) Pacific Islander/Native Hawaiian (PI)
- ( ) White (WH)
- ( ) Asian (AS)

20. Does the scholar have an individualized education plan (IEP), or a 504 plan? *

Mark only one oval.

- ( ) IEP
- ( ) 504
- ( ) Neither
- ( ) I'm not sure.

21. Please list any medical conditions and/or allergies that require medication or treatment by the nurse. (Write "none" or N/A if scholar has none.) *

22. Does the scholar take any prescription medications? (Yes, no, or name them, if you would.) *

23. Does the scholar have an asthma plan to be filed with the nurse? *

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) Maybe

24. Does the scholar have any allergy that requires an Epipen in school? *

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) Maybe

25. Do you have a current, up-to-date immunization record for the scholar? *

Mark only one oval.

- ( ) Yes
- ( ) No

26. Do you have a current health certificate for the scholar? *

Mark only one oval.

- ( ) Yes
- ( ) No

27. Do you have a current dental certificate for the scholar? *

Mark only one oval.

- ( ) Yes
- ( ) No

28. By typing my name below, I indicate that I DO NOT wish for IDEA to use my scholar's image in printed or digital marketing materials, on the school website, in social media, and in other resources.

Parent/Guardian Information

All the necessary information about parents/guardians of the scholar. If the guardian is "other," court-ordered proof of legal guardianship must be provided

29. Guardian #1 (Primary) *

Mark only one oval.

- ( ) Mother
- ( ) Father
- ( ) Other

30. Primary Guardian Last Name - Please type carefully! *

31. Primary Guardian First Name - Please type carefully! *

32. Does this guardian have legal custody of the scholar? *

Mark only one oval.

- ( ) Yes
- ( ) No

33. Primary Guardian Cell Phone Number - Please type carefully! *

34. Primary Guardian Work and/or Home Phone Number(s) - Please type carefully and indicate "work" or "home." *

35. Primary Guardian Email Address - Please type carefully! *

36. Guardian #2 (Secondary) *

Mark only one oval.

- ( ) Mother
- ( ) Father
- ( ) Not Applicable
- ( ) Other:

37. Secondary Guardian Last Name - Please type carefully! *

38. Secondary Guardian First Name - Please type carefully! *

39. Does the secondary guardian have legal custody of the scholar? *

Mark only one oval.

- Yes
- No
- Other:

40. Secondary Guardian Cell Phone Number - Please type carefully! (Type N/A if not applicable.) *

41. Secondary Guardian Work and/or Home Phone Number(s) - Please type carefully and indicate "work" or "home." (Type N/A if not applicable.) *

42. Secondary Guardian Email Address - Please type carefully! (Type N/A if not applicable.) *

43. Who has legal guardianship (custody) of the scholar? *

Mark only one oval.

- Mother only
- Father only
- Both parents
- Other:

44. Is either parent active or retired military? *

Mark only one oval.

- Mother
- Father
- Neither
- Both

45. "Other" Guardian Last Name - Please type carefully! (Type N/A if not applicable.) *

46. "Other" Guardian First Name - Please type carefully! (Type N/A if not applicable.) *

47. Does this guardian have legal custody of the scholar? *

Mark only one oval.

- Yes
- No
- Other:

48. "Other" Guardian Relationship (Type N/A if not applicable.) *

49. "Other" Guardian Cell Phone Number - Please type carefully! (Type N/A if not applicable.) *

50. "Other" Guardian Work and/or Home Phone Number - Please type carefully! (Type N/A if not applicable.) *

51. "Other" Guardian Email Address` - Please type carefully! (Type N/A if not applicable.) *

52. Emergency Contact #1 Last Name (Must be someone other than the parent or guardian listed above.) *

53. Emergency Contact #1 First Name (Must be someone other than the parent or guardian listed above.) *

54. Emergency Contact #1 Cell Phone Number - Please type carefully! *

55. Emergency Contact #1 Work and/or Home Phone Number - Please type carefully! *

56. Emergency Contact #1 Relationship *

57. Emergency Contact #2 Last Name (Must be someone other than the parent or guardian listed above.)

58. Emergency Contact #2 First Name (Must be someone other than the parent or guardian listed above.)

59. Emergency Contact #2 Cell Phone Number - Please type carefully!

60. Emergency Contact #2 Work and/or Home Phone Number - Please type carefully!

61. Emergency Contact #2 Relationship

Previous School Information

(Mandatory for New Students Only)

62. Please indicate the scholar's first year in high school.

Mark only one oval.

- ( ) 2021-22 (this coming school year)
- ( ) 2020-21 (the current pandemic year)
- ( ) 2019-20 (two years ago, before the pandemic)
- ( ) 2018-19 (three years ago)
- ( ) 2017-18 (four years ago)
- ( ) Other:

63. What school does the scholar attend this past year (2020-2021)?

Mark only one oval.

- ( ) Option 1

64. In what state is the current school located?

65. What school did the scholar attend in School Year 2019-2020?

66. 2019-2020 school was located in which state?

Mark only one oval.

- ( ) Option 1

Attachments

If you have a Google email account, you can attach any enrollment paperwork here, including health, dental and immunization forms. You will be asked to sign into your Google account.

67. Please upload any enrollment or health documents here.

Files submitted:

Referral to IDEA

Please tell us how you learned about IDEA!

68. How did you hear about IDEA? *

Mark only one oval.

- ( ) Option 1

69. Which person referred you, or please type N/A. *

Summer Opportunities

Would you be interested for your scholar?

70. In August, IDEA is planning to offer a virtual two-week coding and video game camp for our incoming Timberwolves. Would your scholar be interested in participating? *

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) Maybe

Our Appreciation!!

Thank you for completing this Google form, which is THE FIRST STEP in completing the enrollment process. Please see our website at ideapcs.org or call us at (202) 399-4750 to find out the next steps. We appreciate you and greatly look forward to educating your scholar!

Please complete these last two questions about the form itself. Thank you!!

71. Who completed this form? *

Mark only one oval.

- ( ) Parent/Guardian
- ( ) Mr. Romero
- ( ) Mr. Young
- ( ) Mrs. Harris-Jenkins
- ( ) Ms. Brooks
- ( ) Other:

72. Filling out this form was... *

Mark only one oval.

- ( ) Easy
- ( ) A little difficult
- ( ) Very difficult
- ( ) Other:

73. Your feedback about the form:

You Will Be Able to Edit Your Responses

When you submit your form, you will see a box that says "Edit after submit." Use that if you need to review and edit your responses.

Also, if you also check "Send Me a Copy of My Responses," you will be able to go back in at a later point in time and edit your responses then.

Thanks again!

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DC Residency Verification Form – 2021-22 School Year

Use this form to verify that you are a District resident and therefore you or your student is eligible to enroll in a DC public or public charter school. All forms and supporting residency documentation are submitted to the enrolling school.

Step One: Choose the residency verification method that best applies to you.

Details of the available methods for verifying your DC residency are provided on page two. **Choose ONE** after completing sections 2 and 3 below. To be eligible to enroll in a DC public or public charter school tuition-free: 1) the enrolling person must be the parent, adult student, or the valid legal guardian, custodian or Other Primary Caregiver with proper documentation; 2) **the enrolling person has established a physical presence in the District of Columbia**; and 3) the enrolling person has submitted valid and proper documentation that establishes residency as set forth in law and regulations.

Step Two: Provide information about student and enrolling person.

Student First Name:	**Student Last Name:**	**DOB:**
Name of 2021-22 School Year School:		
Enrolling person > First Name:	**Last Name:**	
I am the: ☐ student's legal parent/guardian/custodian ☐ adult student	☐ student's Other Primary Caregiver and completed the OPC Form ☐ minor parent and completed the sworn statement	
Address of enrolling person:		
City:	**State:**	**ZIP:**
Email:	**Phone:**	

DC Resident: ☐ Yes ☐ No

Step Three: Sign Certification of Residency Requirements.

- I certify that I am the parent or the valid guardian, custodian, or Other Primary Caregiver and am submitting valid and proper residency documentation accordingly or have identified myself as a non-resident and understand the required tuition agreement and tuition payment needed for enrollment.
- I certify that I have established and will maintain a physical presence in the District, defined as the "actual occupation and inhabitance of a place of abode with the intent to dwell for a continuous period of time"; and I am submitting valid and proper documentation to verify residency, as set forth in 5-A DCMR § 5004; or, I have identified myself as a non-resident and will complete the required tuition agreement and tuition payment.
- I consent to the disclosure of whether I was determined to meet the residency requirements for any government funded financial assistance program (such as, Medicaid, TANF, or SNAP) in which I am enrolled for the sole purpose of verifying District residency for DC public or charter school enrollment. By signing below, I am saying: I authorize OSSE to obtain my personally identifiable DC residency status information from other state or federal agencies, including but not limited to, the DC Department of Human Services (DHS), the DC Housing Authority (DCHA), and the Department of Health Care Finance (DHCF). OSSE will protect my information and follow all applicable laws regarding the protection and use of this information.
- I understand that enrollment of the above-named student in District of Columbia Public Schools, 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 submission of valid and proper documentation verifying residency** or by completion of a tuition agreement and tuition payments.
- I understand that even if the documentation I provide appears to be satisfactory, OSSE or school officials, with reasonable basis, may seek further information to verify the student's residency or the Other Primary Caregiver status of the adult enrolling the student.
- If the District of Columbia, through OSSE, determines that I am not a resident or an approved non-resident under 5-A DCMR § 5007, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school.
- I understand that if I provide false information or documentation, I can be referred to DC Office of the Inspector General for criminal prosecution or to the DC Office of the Attorney General for prosecution under the False Claims Act and under D.C. Code § 38-312 which provides that 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 understand that this form and all supporting documentation to this form, including all other OSSE forms used to verify residency, will be retained by the school. I consent to their disclosure to OSSE, external auditors, and other District agencies including but not limited to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request, for the purposes of ensuring the accuracy of my District residency.
- I understand that the District of Columbia may use whatever legal means it has at its disposal to verify my residence.
- **I agree to notify the school of any change of residence for myself or the student within three school days of such change.**

Enrolling Person SIGN HERE: _____ **DATE:** _____

Step Four: Submit this completed form and applicable documentation to your school.

SCHOOL OFFICIAL USE ONLY The following method was used to verify District of Columbia residency. Choose ONE method.

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 and the DC Office of the Attorney General, upon request.

School Official Name (print): _____ **Signature:** _____ **Date:** _____

Method A: School official verified
- ☐ OSSE Residency Verified (QLIK or ASPEN)
- ☐ Homeless liaison verified
- ☐ Ward of DC

Method B: Select one document
- ☐ Pay stub
- ☐ DC Gov. financial assistance
- ☐ Certified DC Tax Form-D40
- ☐ Military housing orders
- ☐ Embassy letter

Method B: Select two documents
- ☐ DC motor vehicle registration
- ☐ DC driver's license/non-driver ID
- ☐ Lease with payment
- ☐ Utility bill with payment

☐ **Method C:** Home visit

☐ **Non-resident**

PROOF OF RESIDENCY DOCUMENTS

(for back of enrollment checklist)

Persons eligible to enroll a student:

- Parent - a natural parent, stepparent, or parent by adoption who has custody or control of a student, including joint custody.
- Guardian - an appointed legal guardian of a student by a court of competent jurisdiction.
- Custodian - a person to whom physical custody has been granted by a court of competent jurisdiction.
- Other Primary Caregiver - is a person other than a parent or court-appointed custodian or guardian who is the primary provider of care or control and support to a student who resides with him or her, and whose parent, custodian, or guardian is unable to supply such care and support due to serious family hardship.
- Adult Student - A student who is 18 years of age or older, or who has been emancipated from parental control by marriage, operation of statute, or the order of a court of competent jurisdiction.

Enrolling person, follow ONE of the methods below to verify DC residency.

ONE item from this list to verify residency.	**OR**	**TWO items from this list to verify residency.**
• ***A valid pay stub issued within 45 days of the school's review of this form.*** Must contain withholding of only DC personal income tax for the current tax year and no other states listed for deduction, even if the amount is zero. It must also show a DC personal income tax withholding amount greater than zero for both the current tax year and current pay period. • Unexpired official documentation of financial assistance from the Government of the District of Columbia, issued to the enrolling person within the past 12 months and 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, etc.*** • Certified copy of Form D40 by the DC Office of Tax and Revenue, with evidence of payment of DC taxes for the current or most recent tax year and must bear the DC Office of Tax and Revenue stamp. • Current military housing orders or statement on military letterhead, must be official correspondence and cite the specific DC address of residence. • Embassy letter issued within the past 12 months. Must contain an official embassy seal and signature of embassy official; and indicate that the enrolling person and student or the adult student currently reside, or will reside, on embassy property in DC during the relevant school year.		• ***DC motor vehicle operator's permit or official government-issued non-driver identification that is valid and unexpired.*** • ***DC motor vehicle registration that is valid and unexpired.*** • ***Lease or rental agreement that is valid and unexpired with a separate proof of payment of rent***, such as receipt of payment, money order, or copy of cashed check. The lease must contain the start date, monthly rent amount, name of landlord, and be signed by the enrolling person and landlord. The separate proof of payment must be for a period within two months immediately preceding the school's review of this form and match the monthly rent amount stated on the lease. • ***Utility bill (only gas, electric, and water bills are acceptable)*** with a separate paid receipt showing payment of the bill, such as receipt of payment printout, money order, or copy of cashed check. The utility bill must be for a period within the two months immediately preceding the school's review of this form. The separate proof of payment must be for the specific bill submitted. The most common submission is two consecutive bills where the second bill shows payment on the first bill. A credited amount on a bill and government agency letter subsidizing payment for utility are also acceptable proofs of payment.

Verify through a home visit. If the family is unable to verify through one of the above methods, a home visit may be conducted remotely or in person.

Other Primary Caregiver (OPC) Form – 2021-22 School Year

Use this form to verify that the enrolling student is under the care of "Other Primary Caregiver." School officials should only collect this form if the person enrolling the student is *NOT* the parent, legal guardian, or court appointed custodian of the student and whose parent, custodian, or guardian is unable to supply such care and support due to serious family hardship.

Step One: Determine if you are an Other Primary Caregiver.

An "Other Primary Caregiver" is a person other than a parent or court-appointed custodian or guardian who is the primary provider of care or control and support to a student who resides with him or her, and whose parent, custodian, or guardian is unable to supply such care and support due to serious family hardship. Other Primary Caregivers must establish DC residency as required on the DC Residency Verification Form, in addition to establishing his/her status as an "Other Primary Caregiver." See reverse for definition of care or control and substantial support.

Step Two: Provide information about your Other Primary Caregiver status.

Student First Name:	**Student Last Name:**	
OPC First Name:	**OPC Last Name:**	
OPC Address:		
City:	**State:**	**ZIP:**
Relationship to enrolling student:	**Date student started residing with OPC:**	

Verify Other Primary Caregiver status (check any that apply):

☐ I provide care or control for the enrolling student
☐ I provide substantial support for the enrolling student
☐ Enrolling student resides with me, the other primary caregiver

Step Three: Provide information about the parent/legal guardian.

Full Name of Parent/Legal Guardian:			
Address of Parent/Legal Guardian:			
City:	**State:**	**ZIP:**	**Phone:**

The parent or legal guardian is unable to provide primary care and substantial support because of the following serious family hardship (check any that apply):

☐ he/she has an active military assignment
☐ he/she suffers from a serious illness
☐ he/she is deceased
☐ he/she is experiencing loss of habitability
☐ he/she is incarcerated
☐ he/she does not live with the child due to neglect and/or abuse
☐ he/she has abandoned the child
☐ he/she is unavailable due to deportation

Step Four: Confirmation of Other Primary Caregiver Status.

By signing below, I swear and attest that I am the Other Primary Caregiver and the parent, custodian, or guardian is unable to supply such care and support because of a **serious family hardship**. I further accept that all provisions set forth in "Step Three: Certification of Residency Requirements" on the DC Residency Verification Form are incorporated and merged herein.

Other Primary Caregiver SIGN HERE: _____ **Date:** _____

SCHOOL OFFICIAL USE ONLY Complete the area below to confirm school verification of other primary caregiver status.

I reviewed the Other Primary Caregiver status as specified above and the OPC meets all three criteria and that the parent or legal guardian is unable to provide primary care and substantial support due to serious family hardship. In addition, the above identified Other Primary Caregiver provided one of the following documents to verify OPC status:

☐ Sworn Statement
☐ Records from the previous school year
☐ Immunization or medical records
☐ Unexpired official documentation from the federal government or the Government of the District of Columbia
☐ Attestation for Other Primary Caregiver

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 and the DC Office of the Attorney General, upon request.

School Official Name (print): _____ **Signature:** _____ **Date:** _____

Other Primary Caregiver must submit one of the documents identified below to verify the other primary caregiver status.

Methods	• **A completed and signed sworn statement** indicating that he/she is the primary caregiver for the student. • **Records from the previous school year** indicating that the student is in the care of the caregiver, including, but not limited to, a signed report card. • **Immunization or medical records** issued within the last 12 months immediately preceding the school's review of the residency documentation, indicating that the student is in the care of the caregiver. • **Unexpired official documentation from the federal government or the Government of the District of Columbia** with an issue date within the last 12 months immediately preceding the school's review of residency documentation, indicating that the caregiver receives public or medical benefits on behalf of the student, including, but not limited to, Supplemental Security Income annual benefits notification or TANF verification of income notice or recertification approval letter. • **An attestation for Other Primary Caregiver completed and signed by a legal, medical or social service professional** attesting to the caregiver's status relevant to the student and issued within the last 12 months immediately preceding the school's review of residency documentation.

Am I an Other Primary Caregiver?

5-A DCMR § 5099 states that an Other Primary Caregiver (OPC) is a person, other than the enrolling student's parent or court appointed custodian or guardian. The enrolling student must *reside* with the OPC and the OPC *must provide the student with guidance, maintenance, physical care and support.* In addition, **the student's parents, guardians, or custodians are unable to provide the student primary care and substantial support due to serious family hardship**. If you do not provide guidance, maintenance, and physical care, and the student's parents, guardians, or custodians do not suffer from a serious family hardship, you do not qualify as an Other Primary Caregiver. Do you provide the following items in the table below?

Support	When the OPC is exercising *primary* responsibility to provide the child with financial resources for the child's livelihood.
Guidance	When the OPC participates in the responsibility for the child's development on a daily basis: • Attending school conferences • Disciplining the child • Participating in decisions concerning the child's well-being • Involvement in the child's extracurricular activities
Maintenance	When the OPC is providing necessities: • Food • Clothing • Shelter
Physical care	When the OPC is providing continuous care for the child by performing tasks required in the child's daily life: • Bathing • Feeding • Dressing • Assuring medical attention will be received by the child • Preparing meals • Supervising the child's activities • Assisting with other physical care needs

Sworn Statement – 2021-22 School Year

This form is to be completed by the person enrolling the student, or by the parent of an adult student or minor parent, in cases when a sworn statement is needed to complete residency verification. For example, use this form in cases where a minor parent is enrolling their child but currently living at home and not able to prove DC residency.

Provide information about individual.

Student First Name:	**Student Last Name:**	
Person completing sworn statement > First Name:	**Last Name:**	
Address of person completing sworn statement:		
City:	**State:**	**ZIP:**
Relationship to enrolling student:		
Email:	**Phone:**	

Identify basis for sworn statement.

Check the appropriate basis for the sworn statement:

☐ I am the parent of an adult student and the student resides with me at the address provided above. Documents establishing DC residency as set forth in 5A DCMR § 5004.2 are attached.

☐ I am the parent of a minor parent and the minor parent and child reside with me at the address provided above. Documents establishing DC residency as set forth in 5A DCMR § 5004.2 are attached.

☐ I am the Other Primary Caregiver of the student as attested in the Other Primary Caregiver form. Documents establishing DC residency as set forth in 5A DCMR § 5004.2 are attached.

Sign and complete the sworn statement.

I solemnly affirm under the penalties of perjury that the contents of the foregoing are true to the best of my knowledge, information and belief. I further accept that all provisions set forth in "Step Three: Certification of Residency Requirements" on the DC Residency Verification Form are incorporated and merged herein.

Signature of person completing sworn statement:_____ **Date:** _____

District of Columbia
Office of the State Superintendent of Education

HOME LANGUAGE SURVEY

As part of the enrollment process in DC public and public charter schools, all parents and guardians must complete the Home Language Survey. For all students who are enrolling in a DC school for the first time, parents must complete the OSSE Home Language Survey at the time of enrollment. The purpose of the three questions below is to determine if your child needs English language proficiency screening. If the answers to questions 1, 2 or 3 indicate a language other than English, the school must screen your child for possible identification as an English learner using a screener test.

All DC residents, of all backgrounds, are welcome in public schools in the District of Columbia.

The Home Language Survey is ***not*** used for immigration purposes and is not shared with Immigration and Customs Enforcement (ICE). The Home Language Survey is ***not*** used to determine:

- your immigration status;
- your residency status; or
- if your child is an English learner.

Please let your school know if you need assistance completing the Home Language Survey.

This form must be signed and dated by the parent/guardian and school official and kept in the student's file.

Student's Last Name _____ Student's First Name _____

School Name _____

1. What is the primary language used in the home? _____

2. What is the language most often used by the student? _____

3. What language or languages did the student use first? _____

For additional information only:
What other languages are spoken in your home? _____

Signature of Parent/Guardian _____ Date _____

Signature of School Official _____ Date _____

To be completed by School Official:
Refer for English language proficiency screening? ☐ Yes ☐ No

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	

Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**

Ethnicity: *(check all that apply)* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer

Race: *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer

Parent/Guardian Name:	**Parent/Guardian Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**

Insurance Type: ☐ Medicaid ☐ Private ☐ None **Insurance Name/ID #:**

Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No

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. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ___/___	☐ NML ☐ ABNL	**Weight:**	☐ LB ☐ KG	**Height:**	☐ IN ☐ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Developmental
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle cell
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:** _____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB? ☐ High → *complete skin test and/or Quantiferon test* ☐ Low	**Skin Test Date:**	**Quantiferon Test Date:**
	Skin Test Results: ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated	
	Quantiferon Results: ☐ Negative ☐ Positive ☐ Positive, Treated	

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date:	**HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
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	Child had Chicken Pox (month & year): Verified by: _____ (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	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____ Dental Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Annual Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

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

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

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

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

_____ _____
Signature of Parent/Guardian or Student if >18 years Date

_____
Print Name of Parent/Guardian or Student if >18 years

Office of the State Superintendent of Education

COVID-19 MEDICAL CONSENT & CERTIFICATION FOR DISTANCE LEARNING

FREQUENTLY ASKED QUESTIONS FOR LOCAL EDUCATION AGENCIES/SCHOOLS

What is the role of the *COVID-19 Medical Consent and Certification for Distance Learning* in planning for the 2021-22 school year?

The *COVID-19 Medical Consent and Certification for Distance Learning* (henceforth "medical certification") documents a student's physical or mental health condition that requires the student to participate in distance learning due to coronavirus (COVID-19). This medical certification is required for any student in pre-kindergarten through 12th grade registering for distance learning for the 2021-22 school year due to COVID-19. Note, this form should not be used for students registering for Home and Hospital Instruction Programs unrelated to COVID-19; such students should adhere to the local education agency's (LEA's) or school's procedures for Home and Hospital Instruction.

What is the LEA's/school's obligation related to approval of a request for distance learning?

Local education agencies (LEAs) and schools should accept any complete and legible medical certification that explains how a student's physical or mental health condition requires the student's participation in distance learning due to COVID-19. Note, as healthcare providers are making individualized decisions regarding the need for distance learning for a given student, LEAs and schools should not question the appropriateness of the clinical determination, as long as the medical certification is complete, legible and explains how the student's physical or mental health condition requires the student's participation in distance learning due to COVID-19.

Is the medical certification required for students requesting distance learning from all grades?

The medical certification is required for any public or public charter student requesting distance learning in pre-kindergarten through 12th grade. Adult education schools must provide in-person activities for students who wish to participate but may also provide a distance learning option without the need for a medical certification from students. Adult education charter schools should also consult with the Public Charter School Board on any additional approvals necessary.

What is the role of school nurses in reviewing a medical certification form?

None. As noted above, LEA and school leaders should accept any complete and legible medical certification that explains how a student's physical or mental health condition requires the student's participation in distance learning due to COVID-19.

If an LEA or school has a question about the medical certification form, is it allowable to follow-up with the physician or nurse practitioner signatory?

Yes. The parental consent section of the medical certification form provides consent to the school and healthcare provider to discuss, release, or exchange information contained in or related to this form, or release information from the student's education and medical records concerning the request for registration in distance learning for the referenced student due to COVID-19.

Can a family member's health condition(s) be documented as justification for the request for distance learning?

No. Only the student's physical or mental health condition that requires distance learning, as documented on the medical certification form by a licensed physician or nurse practitioner, may be used to approve registration in distance learning due to COVID-19.

For how long is the medical certification considered active?

As articulated on page 1 of the form, the medical certification is considered active for the approval of distance learning for one academic semester (or two terms, for schools on a quarterly schedule). Families are required to submit an updated medical certification form in the event of any ongoing medical need requiring distance learning beyond one semester.

Can pre-kindergarten through 12th grade students approved for distance learning participate in in-person extracurricular activities or athletics?

No. Pre-kindergarten through 12th grade students approved for distance learning may not participate in any in-person activities at the school, including extracurricular and athletic activities.

What deadline has been communicated to families and medical providers for submission of the form?

LEAs should define and communicate to families their own deadlines for submission of the medical certification form.

Can a family request distance learning after this initial deadline?

Yes, with appropriate documentation. As students may newly enroll or develop medical conditions that require distance learning throughout the school year, LEAs should plan for additional opportunities for families to submit the medical certification form and register their student in distance learning beyond the initial deadline articulated above.

Can a family rescind its request for distance learning mid-semester?

This decision will be made at the discretion of the LEA/school. Schools are encouraged to allow their students to return to in-person learning as soon as their operations allow and as allowed by a student's healthcare provider. Any student wishing to transition mid-semester from distance to in-person learning should submit documentation from their healthcare provider clearing them to return mid-semester to in-person activities, or as otherwise directed by their LEA/school.

Can LEAs incorporate other paths to allow families to be approved for distance learning in the 2021-22 school year?

No. The only path for families to be approved for distance learning due to COVID-19 in a District public or public charter school is via the submission of a COVID-19 Medical Consent and Certification for Distance Learning form.

Will LEAs be asked to report to OSSE regarding students that have submitted medical certifications?

LEAs and schools should retain all records related to medical certifications and their acceptance for at least three years and must be prepared to disclose such records to OSSE, external auditors and other District agencies, upon request, for the purposes of auditing and verification. LEAs and schools must report attendance for students participating in distance learning in accordance with OSSE guidance.