Roots Public Charter School

ENROLLMENT CHECK-OFF STATUS SHEET

STUDENT N	S(nooi Year	2022-202	23
STUDENT N	AVIE: (Last)	(F:)		Date:
Grade: Circl	le One: (PK-3	(First) (PK-4) (K	(Middle) a) (1) (2) (3) (4) (5)
				J) (+) (J)
• A		N APPLICA		
	o Parent R	Responsibiliti	es/Academi	c/Behavioral
	Support	Contract		
	o PAC Fo	rm & Dues		
	 Languag 			
	o OSSE D	C Residency	Verification	n Form
	RESIDENC	Y DATA (2)	Required)	
		ed Driver's L		
	 Unexpire 	ed Vehicle R	egistration	
	\circ One(1)C	urrent Utility	Bills (PEPC	CO, WASA, GAS
	UNLY) W/	(1) receipt of pay	ment	
	o valid Lea payment	se/Rental Agre	eement & one(1)Separate proof of
	payment	or		
ا ت	RESIDENC	Y DATA (1	Required)	
	o Copy of	Pay Stub	1	
	o SSI/SCH			
	o Poof of V	Vard-of-State	Child	
	CADEMIC	DATA (from	n exiting sch	1001)
	o Report Ca	ard (from pre	evious schoo	1)
	o Standardi	zed Test Sco	res (from pr	evious school)
	 Official V 	Vithdrawal F	orm (from p	revious school)
	EALTH DA		` 1	2 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
		Examination/	Shot Record	10
	 Dental Ex 	amination	SHOT KCCOI	12
Roots Po	CS Verification	n:	Date:	

Roots Public Charter School

RE-ENROLLMENT 2022-2023

REQUIREMENTS FOR RE-ENROLLMENT

Roots Public Charter School is an African Centered school where student success is built around parent involvement and support. Parent *Umoja* (Unity) and Ujima (collective work and responsibility) is the key factor for success and a requirement for enrollment and continued enrollment.

Proof of Parent Involvement & Cooperation for SY 21-'22: Paid PAC dues for SY 2021-'22 x Zero Balance Due to RPCS x Attended Parent/Teacher Conferences Sept. x_Jan._x_March_x_ What fundraisers Did You Support? On Which PAC Committees Did You Work? I volunteered a day or more in the Classroom____ Student Re-enrollment Forms MUST Be Returned on or Before April 1st IN ORDER SECURE YOUR CHILD'S SPACE you must pay your SY 2021-'22 PAC dues <u>I plan to return</u>, so please re-enroll my child for SY 2022- '23__ x___ Student's Name____ Teacher's Name_____ Parent Signature_____ IF YOU ARE NOT RE-ENROLLING, IN ORDER TO ENSURE THE CORRRCT COUNT, PLEASE FILL OUT AND RETURN THIS FORM My child will **NOT** return for **SY 2022 '23___** Student's Name____ Parent Signature_____ Reason____

ROOTS PUBLIC CHARTER SCHOOL

15 Kennedy Street Northwest Washington, DC 20011 Phone: (202) 882-8073 Fax: (202)-882-8075 Web Address: rootspcs.org

ADMISSION APPLICATION

Proposed Entry Date	SY 20	022-2023 Gra	ade	
Student's Name				
Age Sex DOB_	Child	Lives With		
Previous School:		Student ID#		
E-mail:				
Address				
Street	City	State	Zip	
Home#Work#		Cell#		
Parent/Guardian's Name				
Address_				
Dereet	City	State		Zip
Home#Work #	Cell#_			
	00000			
Signature of Parent or	Guardian)ate	

ROOTS PUBLIC CHARTER SCHOOL 15 Kennedy Street Northwest

Washington, DC 20011

ENROLLMENT APPLICATION

School Year: 2022-'23

Student Information					
Grade in SY 2022-2023: (Print all information)			Student	t ID#:	
First Name	Middle Name		Last Name		Suffix
Date of Birth	Gender (circle One) Female Ma	le N	ace/ Ethnicity(choo Black lativeWhite Hispanic Or	Asian	_ American Indian/Alaska
Name of Last School Attended	City/State of last sch	A	ate Last ttended //		Last Grade Completed
Does student have Health iss Yes No If yes, give description: City/State of Birth					ry of Citizenship
Student's Residential Address	3	Apartı	ment No.	Ward	
City		Student's	mailing address ((if different	from residential address)
Residency Status (Check One) DC Resident (Student & Parent/Legal Guardi Non-resident (Student & Parent/Legal Guardi	an live in DC)	City			Ward
DC) Receipt of non-resident tuition attached		informa	fy that the in rate. I unders tion for purpo ent is punisha	tand tha ses of d	on given on this form t providing false defrauding the aw.
Signature of Parent/Legal Guardian with Whom the			Date		

Applicants for admission are hereby notified that Roots PCS, does not discriminate on the basis of race, color, sex, national origin, age, disability, special needs, political beliefs, sexual orientation, or marital and family status in admission or access to, or treatment in its programs and activities.

School	Year	
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Parent/Guardian EMERGENCY CONTACT Information

Provide parent/legal guardian names.

Provide Contact information if different from student's

Parent/Guardian(1) C First Name MI	Last Name		ian(2) Contact Information
		First Name MI	Last Name
Street Address (if different from	m student)	Street Address (if different	ent from student)
Apt#	Ward	Apt#	Ward
City		City	
State	Zip Code	State	Zip Code
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone		Cell Phone	
E-mail Address		E-mail Address	
(Other than pare	NTACT Information (1) ent/guardian)	EMERGENCY CO	ONTACT Information (2) han parent/guardian)
Other than pare	NTACT Information (1) ent/guardian)	(Other t)	ONTACT Information (2) han parent/guardian)
Name Address	NTACT Information (1) ent/guardian)	(Other t)	ONTACT Information (2) han parent/guardian)
Name Address	NTACT Information (1) ent/guardian)	Name (Other the	ONTACT Information (2) han parent/guardian)
Other than pare Name Address Relationship	NTACT Information (1) ent/guardian)	Name Address	ONTACT Information (2) han parent/guardian)
Name Address Relationship Primary Phone	NTACT Information (1) ent/guardian)	Name Address Relationship Primary Phone	han parent/guardian)
Name Address Relationship Primary Phone	NTACT Information (1) ent/guardian)	Name Address Relationship	han parent/guardian)
Name Name Address Relationship Primary Phone	ent/guardian) ACT Information (3)	Name Address Relationship Primary Phone Alternate Phone	han parent/guardian) CONTACT Information (4)
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Name Name Address Relationship Primary Phone Alternate Phone EMERGENCY CONTA	ent/guardian) ACT Information (3)	Name Address Relationship Primary Phone Alternate Phone EMERGENCY C (Other than p	han parent/guardian) CONTACT Information (4)

Please Note: In a case of emergency the Administration will contact the mother, father, or Legal Guardian; if neither can be reached, the **first** person on the Authorized Emergency List will



Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Parent First Name:	Part 1: Child Pers	onal Info	rmation	ı Tob	e compl	eted by r	are	nt/guardi	a h					Ki waji		
School or Child Care Facility Name:	Child Last Name:								all.			<u> </u>		-6 Di ul		30 din 1
Home Address:	School or Child Care Fa	cility Name:				<u>!</u>			Gol	adar.					: 	
Ethnicity: (cores of those apply) Mispanic/Latino Non-Hispanic/Non-Latino Other Prefer not to answer Prefer not Alaska Native Parent First Name: Parent Last Name: Parent Fine: Pa	Home Address:					Δnt·		City	Juci	iuei.				Female		lon-Binary
Annerican Indian	Ethnicity: (check all that ap	oly) 🔲 Hi	ispanic/Lat	ino			io/61-					State	2: 		<u> </u>	
Parent Last Name:	Race: (check all that apply)	☐ At	nerican Inc	dian/				Native Ha		<u> </u>		frican			not to a	nswer Prefer no
Emergency Contact Name:	Parent First Name:		doka realivi		arent lac	t Namo		Pacific Isla	ander				- 77072_			to answe
Insurance Type: Medicaid Private None Insurance Name/ID 8; Mass the child seen a dentist/dental provider within the last year? Yes No No None N	Emergency Contact Nan	 ne:			arene Lus			<u> </u>			·		ne:			
Has the child seen a dentist/dental provider within the last year? yes No	Insurance Type:	Medicaid	П р	ivoto I					····	ку Со	ntact Pho	one:				
ligive 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 immit against in addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immit against in addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immit against in addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immit agree that this form with my child's school, its employees and agents shall be immit active. I here the District that this form should be completed and returned to my child's school every year. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be completed by licensed health care provider. Part 2: Child's Health History, Exam, and Recommendations To be complete	Has the child seen a der						ance		#:					····		
MANI Weight: Lis Height: IN BMI: BMI: BMI: Mormal Percentile:	from civil liability for acts understand that this forn Parent/Guardian Signatı	or omission should be re:	ns under D completed	C Law 17 I and retu	-107, exc urned to i	ept for cri my child's	u agr imina scho	ee that th al acts, inte ool every y	e District entional v ear.	, the s wrong	chool, its doing, gr	s employ oss negl	/ees igen	and age ce, or wi	nts shal Ilful mis	l be immu sconduct.
MANI Weight: Lis Height: IN BMI: BMI: BMI: Mormal Percentile:	Date of Health Evame	th Histo	ry, Exam	i, and	Recom	menda	tion	s Tob	e compl	eted l	y licens	ed hea	lth c	are pro	vider.	7
Autism	Sate of Health Exam:		BP: /	<u>_</u>		Weight:		LB LB							A COUNTY OF THE PARTY.	
Left eye: 20/	lision				ABNL			☐ KG				СМ			Per	centile:
Asthma	creening: Left eye:		_ Right ey	/e: 20/						□ v	Vears gla	sses 🗆	Re	eferred		Not teste
Asthma	learing Screening: /check	all that apply)				Pass		Fail	·		lot tested	4 D	1110	oc Dovice	<u>, n</u>	D-£
B 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?	Cancer Cerebral palsy Development Diabetes	Languag Obesity Scoliosis Seizures	se/Speech	lease att	Long-te Details p Significa Details p	erm medic provided be ant health provided be	ation low. hist low.	ns, over-th ory, condi	e-counte	er-drug Imunio	gs (OTC) o	or specia ess, or re	al car	re requir	ements	
What is the child's risk level for TB? High → complete skin test and/or Quantiferon test Low Quantiferon Results: Negative Positive, CXR Negative Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive, CXR Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive, Treated Additional notes on TB test: Positive, CXR Positive Positive, CXR Positive Positive, CXR Positive Positive, Treated Additional notes on TB test: Positive, CXR Positive Positive, CXR Positive Positive, CXR Positive Positive, CXR																
High → complete skin test and/or Quantiferon test Low Quantiferon Results:	B Assessment Positiv	e TST should		u co i iiiii	ary Care P	hysician f	or eva	aluation. Fo	or questic	ns call	T.B. Con	trol at 20	12-69	98-4040		18 19 19 19 19 19 19 19 19 19 19 19 19 19
and/or Quantiferon test Quantiferon Results: Negative Positive, CXR Negative Positive, CXR Positive Positive, Treated Additional notes on TB test: Read Exposure Risk Screening All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607 PONLY FOR CHILDREN Ist Test Date: 1st Result: Normal Developmental Screening Date: 2nd Result: Normal Developmental Screening Date: 2nd Serum/Finger Stick Lead Level: Developmental Screening Date: 2nd Serum/Finger Stick Lead Level: Stick Lead Level: Developmental Screening Date: 2nd Serum/Finger Stick Lead Level: Stick Lead Le		ACLIOLID:	Skin Test	Date:					Q	uantif	eron Tes	t Date:		0 10 10.		
Quantiferon Results: Negative Positive Positive, Treated Additional notes on TB test: Read Exposure Risk Screening All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607 PNLY FOR CHILDREN In Test Date: 1st Result: Normal Abnormal, Developmental Screening Date: 2nd Test Date: 2nd Result: Normal Abnormal, Developmental Screening Date: 2nd Serum/Finger Stick Lead Level: Developmental Screening Date: 2nd Serum/Finger Stick Lead Level: 2nd Ser			Skin Test	Results:		Negative	. [Positive	e, CXR Ne	gative	Po	sitive. CX	R Po	sitive [Posit	tivo Tronto
Additional notes on TB test: Page Comparison All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607 Page Comparison All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607 Page Comparison Call 202-654-6002 or Fax: 202	-	cst	Quantife	ron Resu	lts: 🔲	Negative	Γ	¬							1 031	uve, freate
PALLY FOR CHILDREN INDER AGE 6 YEARS Very child must have lead tests by age 2 CORDINATION 1st Result: Normal No								- rositive			Po	sitive, Tre	eated			
Interpretable in the particular of the particular in the particula	ead Exposure Risk Scr	ening A	l lead levels	must be	reported	to DC Chil	dhaa				12.2200		1510.00			
lead tests by age 2 2nd Test Date: 2nd Result: Normal Abnormal, Developmental Screening Date: Stick Lead Level:	NDER AGE 6 YEARS	t Test Date		1st Re	esult:		$\mid \sqcup$	Abnorma	d,			u2-654-6	1:	L st Serun	n/Finge	r
GR/HCT Test Date:	very child must have lead tests by age 2	d Test Date	:	2 nd Re	esult:	Normal		Abnorma	l,				2	2 nd Serur	n/Finge	
	GB/HCT Test Date:			_3					- Jureenir	ig nate	·		[_3		u LEVEI:	·

Part 3: Immunization Informat	ion To be com	oleted by license	d health	Caro pro			
Immunizations	Provide in th	e boxes below the	dates of	Lare or o	vider.		
Diphtheria, Tetanus, Pertussis (DTP, DTaP) 1	2 3	uates of	4	TION (IMIM/DD/YY) 	×
DT (<7 yrs.)/ Td (>7 yrs.)	1	2 3		4			
Tdap Booster	1		(=====================================			 	1
Haemophilus influenza Type b (Hib)	1	2 3	<u> </u>	4			
Hepatitis B (HepB)	1	2 3		4			
Polio (IPV, OPV)	1	2 3		4			
Measles, Mumps, Rubella (MMR)	1	<u> </u>				-	
Measles	1	2					· · · · · · · · · · · · · · · · · · ·
Mumps	1					- <u>-</u>	<u> </u>
Rubella	1	· · · · · · · · · · · · · · · · · · ·		and the same of the same of the			
Varicella	1 :	· Chi	ld bad Ch				
Pneumococcal Conjugate	1 [2		ru nau Cn	icken Pox	(month & year):		
Hepatitis A (HepA) (Born on or after 01/01/2005)	h 2					-	
Meningococcal Vaccine	1 2		* * **********************************	 			
Human Papillomavirus (HPV)	1 2	13		ļ		**************************************	
Influenza (Recommended)	4 2	3					
Rotavirus (Recommended)	1 2			-	5	6	7
						Í	
☐ The child is behind on immunizations	and there is a plan ir	n place to get him/	her back	on schedu	le. Next appointm	ant ic	
Medical Exemption (if applicable)					The state of the s		
I certify that the above child has a valid med Diphtheria Tetanus		·	nized at th	he time ag	ainst:		
	Pertussis	Hib	u	НерВ	Polio		☐ Measles
Mumps Rubella	Varicella	Pneumococcal		НерА	☐ Meningoo	coccal	☐ HPV
Alternative Proof of Immunity (if applicable) certify that the above child has laboratory e	vidence of immunity	+a +b - £.11		F2 82			
			nd I've at	tached a c	opy of the titer re	sults.	
	Pertussis	Hib	Ц	НерВ	Polio		☐ Measles
☐ Mumps ☐ Rubella ☐	Varicella 🛄	Pneumococcal		НерА	☐ Meningoo	occal	☐ HPV
Part 4: Licensed Health Practition This child has been appropriately examined as tems specified on this form. At the time of th chool, camp, or child care activities except as this child is cleared for competitive sports. Ac	nd health history rev le exam, this child is s noted on page one.	riewed and recorder in satisfactory hea		or an arm discount of the same	th the No	Yes	pending additional
hereby certify that I examined this child and	the information reco	orded here was do	tarminad			clea	rance
Licensed Health Care Provider Office St	amp Provide			os a (6501)	o the examination	on.	
	0.145		i 10 (2		75.55	2000	8
	Provide	Phone:					
	Provider	Signature:	550 10			112	pm p
	Date:		E 15		* 111 DE 311	28 - 6	
cess health insurance programs at heaps://sichouki	Makazon, You may cor	ntact the Health Suite	e Personne	el through t	ne main office at you	er child's sch	00
7 16 OJE ONET Universal Healt	n Certificate receiv	ed by School Off	icial and	l Health S	uite Personnel	27.11.0 3 30()	
cnool Official Name:		Signature:				Date:	
ealth Suite Personnel Name:		Signature:			· <u>- · · · · · · · · · · · · · · · · · ·</u>	Date:	

ACADEMIC AND BEHAVIORAL CONTRACT

Between

Parent/Student and Roots Public Charter School

Roots Public Charter School maintains high academic and behavioral standards. Students must be self-motivated and self-disciplined. Therefore, as a parent I promise to ensure:

1. that I will supervise all homework assignments.

2. that my child completes correctly all homework assignments.

3. that I will review and sign my child's weekly academic grade report provided by the teacher.

4. that if my child's weekly academic grade report reflects poor performance, I will supervise my child's home free time to assist in enhancing knowledge in areas of weakness.

5. that my child is obedient, respectful, and demonstrates acceptable behavior.

6. that following suspension of my child for reasons of behavior, I will accompany the child to school and spend the day as part of in-school suspension.

7. that if my child is found to have a weapon (of any type) in school, I understand in compliance with the Gun-Free Schools Act, my child will be Expelled from RPCS for one year, and referred to the Juvenile Delinquency System.

8. that I am responsible for all information contained in correspondence sent home with my child.

9. that my child attends school daily with all school supplies.

10.that all textbooks issued to my child will be returned in satisfactory condition, otherwise I will be charged the cost of the textbooks.

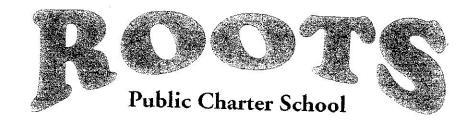
11 that I will support all school community fundraisers.

12.that I will attend all parent meetings.

13.that I will be an active PAC member, donating supplies and volunteering a day or more in the classroom.

I understand that breech of this contract could result in the dismissal of my child from Roots Public Charter School.

Agreed:		¥	
Parent/Guardian Signature	Date	Bernida Thompson, Principal	Date
Child's Name		, , , , , , ,	Date



ENROLLMENT AND SUPPORT AGREEMENT

I/We, the undersigned hereby enrollin the School (hereinafter "Roots") for the school users at the	Roots Dublic Charter
through the school year through	Ma aro in full
agreement with the Roots' mission, philosophy and parent involvement abide by the policies that are outlined in the Parent /Student Handboo and understand. I/We further agree and understand that enrollment is completion of a parent orientation session. This session is crucial to my school's structure/design, methodology, and what is expected of me/u with my/our child/children.	t rules. I/We agree to k, which we have read contingent upon my/our
I/We understand that Roots will take precautions for my child's health consent without liability to anyone acting on behalf of Roots, to secure attention to administer any medicine/treatment that I bring to Roots for becomes ill or involved in an accident and I cannot be contacted, I authorished or accompany her/him in an ambulance to the hospital for treatm	and provide First Aid or him/her. If my child
I/We accept responsibility for any necessary expense in the medical trewhich is not covered by the following:	atment of my child,
Health Insurance Company:	
Policy #:	
/We consent that my/our children can participate in all Roots' field trip activities without liability to anyone acting on behalf of Roots. I also con participation in print, video, broadcast, or published media related to th compensation or ownership rights.	sent to our family's
Accepted by:	
Roots PCS Administration	Date
Parent/Legal Guardian	Date

15 Kennedy Street, Northwest Phone: 202.882.8073

Washington, DC 20011 Fax: 202.882.8075

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.

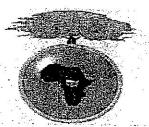
The Home Language Survey is **not** used for immigration purposes and is not shared with Immigration and Customs Enforcement (ICE). The Home Language Survey is **not** used to determine:

- 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.

Last Name	Student's First Name
School Name	
1. What is the primary language used in the	e home?
	the student?
3. What language or languages did the stud	lent use first?
For additional information only: What other languages are spoken in your h	ome?
Signature of Parent/Guardian	Date
Signature of School Official	Date
To be completed by School Official: Refer for English language proficiency scree	United 1
Home Language Survey	



ROOTS PUBLIC CHARTER SCHOOL PAC COMMITTEE SIGN - UP FORM

Please PRINT Clearly Parents Name: _ Child's Name: Child's Grade: Address: Phone No: () ______ Best time to call: AM PM Email address: Per your parent contract each parent is to join a PAC (Parent Advisory Council) Committee and participate each month. 1. Please choose ($\sqrt{}$) one of the following committees and return this form to the PAC Committee Sign up table. 2. Fill out the Committee Roster that you selected and pick up a letter with vour Chair's contact data. □ Classroom Helpers and Substitutes: Arranges for parents to substitute when teachers are absent, and periodically helps out in the classroom. From time to time makes phone calls to parents for reminders. □ Publicity/Educational Affairs Committee: Makes fliers, posters and tickets for fundraisers, writes and post various articles in community news. Send alumni fliers about fundraisers and past students. □ Maintenance Committee: Helps to maintain the upkeep of the school, and shovels snow on snow days. Responsible for Set up and Clean-up for all school fundraisers and Events. □ Hospitality Committee: Helps prepare and serve food during all school events (Open House, Parent Orientation, Masquerade, Family Fun Day, End of the year recital, graduations, etc.) □ Curriculum and Educational Affairs: Updates Performance objectives as needed, assist students with preparing for the science fair, spelling bee, geography bee coach and/or judge etc. Participate in Reality Store, when applicable. □ Fundraising/Grants Committee: Helps coordinate events (Skate Party, Masquerade Ball etc.). Responsible for Box Tops coordination. Helps find Grants and sponsors for the Brick project.

Secretarial Committee: Creates updated Parent Directory, makes phone calls to arrange volunteer schedule for events, types various documents for teachers/staff, etc. Sends out group emails of who owes and who paid

□ <u>Supplies Committee</u>: Provides various school supplies and snacks each month throughout the year, as well as provides snacks during Standardized Test Week. Donates office and educational material when needed.



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

Part 1: Child Personal In	nformation	To be con	noleted by	narent/guardia	The Realth 30	ite i ersorii	ici ciliougii c	ne main off	ce at your child's so
Child Last Name:			Child Firs	t Name:			ASS - 1		
School or Child Care Facility Na					Gender:			of Birth:	
Home Address:			Apt:	City:	Gender:		1ale La	Female	Non-Binary
Ethnicity: (check all that apply)	Hispanic/Lat	ina D					State:		ZIP:
Race: (check all that apply)	American Inc Alaska Nativ	dian/ 🔲 A	lon-Hispanic Isian	Native Hawa		Other Black/Afr	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Prefer no White	ot to answer Prefer no
Parent/Guardian Name:	- Industry	· · · · · · · · · · · · · · · · · · ·		Pacific Island		Americar			answer
Emergency Contact Name:				i	rent/Guardia				
Insurance Type:	l 🔲 Privat	e 🔲 No	no Incura	nce Name/ID #:	ergency Con	tact Phon	ne: 		
Has the child seen a dentist/den		[16]		Yes					
give permission to the signing he appropriate DC Government ager from civil liability for acts or omis anderstand that this form should Parent/Guardian Signature:	sions under DC be completed a	Law 17-107, and returned	except for cr to my child's	iminal acts, inten s school every yea	District, the s tional wrong ir.	chool, its doing, gro	employees oss negliger	and agent ace, or will	s shall be immun ful misconduct. I
art 2: Child's Health His	tory, Exam,	and Reco	mmenda	tions To be	completed I	ov license	ed health.	care nrov	der
ate of Health Exam:	BP:	☐ NML	Weight:	☐ LB	Height:		□ ім ВМ		BMI
		ABNL		☐ KG	ļ		O _{CM}		Percentile:
sion reening: Left eye: 20/	_ Right eye: 20	/	Corr	ected	П.				
earing Screening: (check all that opp			Unco	orrected	·	/ears glas	ses 🔲 R	eferred	Not teste
pes the child have any of the fol			Pass	□ Fail		ot tested	u u	ses Device	Referred
Autism Heart for Behavioral Kidney Cancer Language Cerebral palsy Obesity Developmental Scoliosis Diabetes Seizures Ovide details. If the child has Rx, te.	failure ge/Speech	Long-1 Details Signifi Details Other	term medica provided belo cant health l provided belo	tions, over-the-co w. nistory, condition w.	ounter-drugs , communica	(OTC) or : ble illness	special care	e requirem tions.	ents.
		Sylvenesses services	277 223 m2742						
B Assessment Positive TST sho			re Physician f	or evaluation. For	questions cal	T.B. Cont	rol at 202-6	98-4040	
	D2 Skin Tact	Date:			Quantif	eron Test	Date		
hat is the child's risk level for Ti							oute.		
hat is the child's risk level for Ti $1_{\text{High}} \rightarrow \text{complete skin test}$	Skin Test	Results:	Negative	Positive, C	XR Negative			sitive [Positive Treater
hat is the child's risk level for Ti	Skin Test Quantifer					Pos	itive, CXR Pa		Positive, Treated
 that is the child's risk level for Till High → complete skin test and/or Quantiferon test Low 	Skin Test		Negative Negative	Positive, C		Pos			Positive, Treated
that is the child's risk level for Till High → complete skin test and/or Quantiferon test Low Iditional notes on TB test:	Skin Test Quantifer Results:	on [Negative	Positive	XR Negative	Pos	itive, CXR Po	d	
That is the child's risk level for Till High → complete skin test and/or Quantiferon test Low Iditional notes on TB test: Add Exposure Risk Screening NLY FOR CHILDREN DER AGE 6 YEARS	Skin Test Quantifer Results: All lead levels r ate:	on [Negative	Positive Idhood Lead Poiso Abnormal,	XR Negative	Pos	itive, CXR Po itive, Treated 2-654-6002	or fax 202-	535-2607. /Finger
/hat is the child's risk level for Ti High → complete skin test and/or Quantiferon test Low Idditional notes on TB test: Low Screening	Skin Test Quantifer Results: All lead levels r ate:	nust be report	Negative	Positive	XR Negative Ning Preventions Creening Date:	Pos Posi on. Call 20	itive, CXR Po	or fax 202	/Finger Level: /Finger

Child Last Name:		Child First N	censed health		- A	
Immunizations	In the hove				Date of	f Birth:
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	e the dates of in	nmunization (N	IM/DD/YY)	<u> </u>
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4		
Tdap Booster	1	· · · · · · · · · · · · · · · · · · ·				
Haemophilus influenza Type b (Hib)	<u>h</u>	2	13			
Hepatitis B (HepB)	1	2	3			
Polio (IPV, OPV)	1	[2	3	ļ,		
Measles, Mumps, Rubella (MMR)	 					
Measles	ļ	[2	annels administrative description of the constraint of the constra			
Mumps	<u> </u> 			tion of the contract of the second		
Rubella	1		ļ <u>.</u>			
f. 4 - 0	1					
Varicella			Child had Chick Verified by:	ken Pox (month	& year):	
Pneumococcal Conjugate	ā	2	3 3	4		(name & title
Hepatitis A (HepA) (Born on or after	1	2	1	 	-	
01/01/2005)				*).
Meningococcal Vaccine	1	2	The state of the s	The Charles of the Control of the Co		
luman Papillomavirus (HPV)	1	2	3			
nfluenza (Recommended)	l	2	3	4	5 6	7
otavirus (Recommended)	1	2	3			
ther		<u> </u>	3	 	ļ <u> </u>	
					15	
evital exemption (if applicable)		The second secon			t appointment is:	7
edical Exemption (if applicable)	l contraindicat	The second secon	mmunized at the	e time against:		
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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

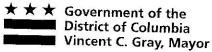
- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)		
First Name Last Name School or Child Care Facility Name	Middle Initial	
Date of Birth (MMDDYYYY) Home Zip Code		
School Day- Grade care PreK3 PreK4 K 1 2 3 4 5 6 7 8 9	Adult 10 11 12 Ed.	
Part 2: Student's Oral Health Status (To be completed by the dental provide	")	
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).	Yes No	
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 I	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?		
Q8 What type of dental insurance does the patient have? Medicaid Private Insurance Oth	er None	
Dental Provider Name Dental Office	. 1	
Dental Provider Signature	e Stamp	
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.

Asthma Action Plan

			ACCIOIT 1	IGIF	
Name	Date of	Birth	Date		
Health Care Provider	Provider	's Phone	/ /	TOP	GREEN means Go! Use CONTROL medicine daily
Parent/Responsible Person	Parent's	Phone	School	40p	YELLOW means Cautio Add RESCUE medicine
Additional Emergency Contact	Contact	Phone	Last 4 Digits of SS#	407	RED means EMERGENC Get help from a doctor now!
Asthma Severity (see reverse	e side) Asth	ma Trigger	s Identified (Things th	at make your esthan	
☐ Intermittent or	1 00	lds 🗆 Smoke	(tobacco, incense)	Pollen Dust Das-	
Persistent: \square Mild \square Moderate \square	Severe 🗀 Str	ong odors [Mold/moisture 🗀 Pest	ts (rodents, cockroach	mals Last Flu
Asthma Control	I STr	ACC/AMATIANA	Cachenana	CI	es) Shot:
☐ Well-controlled ☐ Needs better o	control 🗆 Sea	ason: Fall, V	linter, Spring, Summer	r 🗆 Other	
Green Zone: Go!-Tak	ce these	CONTRO	OL (PREVENTIO	N) Medicines	EVEDY Day
You have ALL of these:	☐ No conti	rol medicines	required. Always rinse	mouth after using you	r daily inhaled medicine.
Breathing is easy				***	
No cough or wheeze	for any con	constraint or infor-	od ovodrum skal Vspragov leg 10-ag	183	times a day
• Can work and play	- Walter car	ensione i		, nebulizer trea	tment(s) times a day
• Can sleep all night	interference and		<u> </u>	, take by mouth	once daily at bedtime
Peak flow in this area:		ma with exer			are bodeline
to			- (())	I with spacer 15 minu	tos hafa
(More than 80% of Personal Best)	For pasa	ng inhelial 1 and		i with space 13 mmu	tes before exercise
Personal best peak flow:		venvironmen	tal allergy, <u>ADD:</u>		ļ
Yellow Zone: Caution	!-Contin	ue CONT	ROL Medicinos	and ADD BECO	Tir sa e :
You have ANY of these:		ide COM	WOL MEDICINES	and ADD KES	.UE Medicines
• First sign of a cold		ilseka. J. odenisi	puff(s) MDI with	spacer every h	nours as needed
Cough or mild wheeze	OR	Welen a supplied		, <u> </u>	iodis as needed
• Tight chest			nahulizar tarata		
Problems sleeping, working, or playing	Factor Englis	La tilizat i i veniga laviga.	nebulizer treatm	herrics) every ho	ours as needed
Peak flow in this area:	☐ Other				
000 C (2000 C 2000 C 20	100	VOUR DOCT	70 if !		
to (50%-80% of Personal Best)	can	a week.	OR if you have these s or if your rescue med	signs more than two	times /
Red Zone: EMERGENC	Y!-Con1	inue CO	NTROL & RESC	IIE Modisines	and CET UP D
You have ANY of these:					
· Can't talk, eat, or walk well	Factor Strong	What is county	., puff(s) MDI with	spacer <u>every 15 minut</u>	es, for <u>THREE</u> treatments
Medicine is not helping	OR				
Breathing hard and fast Blue lips and fingernails			, nebulizer treatm	ent every 15 minutes	for <u>THREE</u> treatments
Tired or lethargic	Fat acting no				
Ribs show	Other	Ca	ll your doctor while g	iving the treatment	5.
eak flow in this area:		TANIAIAT C	ONTAGENIA		
Less than	11 100 (CANNOT	ONTACT YOUR DO	OCTOR: Call 911	for an ambulance
ess than 50% of Personal Best)		or go	directly to the Em	ergency Departn	nent!
QUIRED Healthcare Provider Signa	ture:	SCHOOL MED	ICATION CONSENT AND F	PROVIDER ORDER FOR C	HII DREN/YOUTH
Data	Ì	Possible side eff Healthcare Prov	eco di Tesche inegicines (e.a.	. albuterol) include tachycai	rdia, tremor, and nervousness.
QUIRED Responsible Person Signat		This stude	nt is capable and approved to	Self-administer the modic	
Conco Responsible Person Signat		iiiis stade	in the trior abbitoned to self-we	dicate.	nets) named above.
Date:		As the RESPONS I hereby a	ilBLE PERSON: uthorize a trained school emp	olovee if available +e ===	nictor madical
low up with primary doctor in 1 w	eek or:				
		☐ I hereby a	thorize the student to posse	ss and self-administer medi	cation.
Phone:			knowledge that the District a lability for acts or omissions to wrongdoing, gross population		and agents shall be immune
	L	intentiona	wrongdoing, gross negligen	ce, or willful misconduct.	



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