Roots Public Charter School

ENROLLMENT CHECK-OFF STATUS SHEET

School Year 2022-2023

STUDENT NAME: _____ **Date:**_____
(Last) (First) (Middle)

Grade: Circle One: (PK-3) (PK-4) (Kg) (1) (2) (3) (4) (5)

- **ADMISSION APPLICATION**
  - Parent Responsibilities/Academic/Behavioral Support Contract
  - PAC Form & Dues
  - Language Survey
  - OSSE DC Residency Verification Form
- **RESIDENCY DATA** (2 Required)
  - Unexpired Driver's License
  - Unexpired Vehicle Registration
  - One(1)Current Utility Bills (**PEPCO, WASA, GAS ONLY**) w/(1)receipt of payment
  - Valid Lease/Rental Agreement & one(1)Separate proof of payment

or

- **RESIDENCY DATA** (1 Required)
  - Copy of Pay Stub
  - SSI/SCHIP/TANF
  - Poof of Ward-of-State Child
- **ACADEMIC DATA** *(from exiting school)*
  - Report Card (from previous school)
  - Standardized Test Scores (from previous school)
  - Official Withdrawal Form (from previous school)
- **HEALTH DATA**
  - Physical Examination/Shot Records
  - Dental Examination

Roots PCS Verification:_____ 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**

I plan to return, 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 **2022-2023** Grade _____

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_____
Street City State Zip

Home#_____ Work #_____ Cell#_____

_____ _____
Signature of Parent or Guardian **Date**

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 ID#: _____

First Name	Middle Name	Last Name	Suffix

Date of Birth	Gender (circle One)	Race/ Ethnicity(choose one or more)
_____/_____/_____	Female Male	_____Black ____Asian____ American Indian/Alaska Native ____White _____Hispanic Origin____ Other

Name of Last School Attended	City/State of last school	Date Last Attended	Last Grade Completed
		____/_____/_____	_____

Does student have Health issues requiring emergency response?
☒Yes ___ No___

If yes, give description: _____

City/State of Birth	County of Birth	Country of Citizenship

Student's Residential Address	Apartment No.	Ward

City	Student's mailing address (if different from residential address)	

Residency Status (Check One) ☑
- ☐ DC Resident (Student & Parent/Legal Guardian live in DC)
- ☐ Non-resident (Student & Parent/Legal Guardian live outside DC)
- ☐ Receipt of non-resident tuition attached

City	Ward

I certify that the information given on this form is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law.

_____ _____
Signature of Parent/Legal Guardian with Whom the Student Lives 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_____

Parent/Guardian EMERGENCY CONTACT Information

Provide parent/legal guardian names. Provide Contact information if different from student's

Parent/Guardian(1) Contact Information		Parent/Guardian(2) Contact Information	
First Name MI Last Name		First Name MI Last Name	
Street Address (if different from student)		Street Address (if different 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	

EMERGENCY CONTACT Information (1) (Other than parent/guardian)	EMERGENCY CONTACT Information (2) (Other than parent/guardian)
Name	Name
Address	Address
Relationship	Relationship
Primary Phone	Primary Phone
Alternate Phone	Alternate Phone

EMERGENCY CONTACT Information (3) (Other than parent/guardian)	EMERGENCY CONTACT Information (4) (Other than parent/guardian
Name	Name
Address	Address
Relationship	Relationship
Primary Phone	Primary Phone
Alternate Phone	Alternate Phone

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 be contacted.*

DC | HEALTH

Universal Health Certificate

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.

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 First Name: | **Parent Last Name:** | **Parent 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
- ☐ Development
- ☐ 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.

Immunizations	Provide in the boxes below 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):				
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				

☐ 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

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.** Additional clearance(s) needed from: _____ ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance

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:

Access health insurance programs at [illegible]. You may contact the Health Suite Personnel through the main office at your child's school.

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:**

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 _____

ROOTS

Public Charter School

ENROLLMENT AND SUPPORT AGREEMENT

I/We, the undersigned hereby enroll_____in the Roots Public Charter School (hereinafter "Roots") for the school year ____through_____. I/We are in full agreement with the Roots' mission, philosophy and parent involvement rules. I/We agree to abide by the policies that are outlined in the Parent /Student Handbook, which we have read and understand. I/We further agree and understand that enrollment is contingent upon my/our completion of a parent orientation session. This session is crucial to my/our understanding the school's structure/design, methodology, and what is expected of me/us in the school' success with my/our child/children.

I/We understand that Roots will take precautions for my child's health and safety. I/We give consent without liability to anyone acting on behalf of Roots, to secure and provide First Aid attention to administer any medicine/treatment that I bring to Roots for him/her. If my child becomes ill or involved in an accident and I cannot be contacted, I authorize Roots to take my child or accompany her/him in an ambulance to the hospital for treatment.

I/We accept responsibility for any necessary expense in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Policy #: _____

I/We consent that my/our children can participate in all Roots' field trips and school-based activities without liability to anyone acting on behalf of Roots. I also consent to our family's participation in print, video, broadcast, or published media related to the school without compensation or ownership rights.

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

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? _____

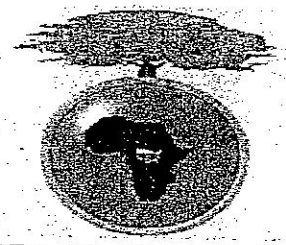
For additional information only:
What other languages are spoken in your home? _____

_____

Signature of Parent/Guardian _____ Date _____

Signature of School Official _____ Date _____

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



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 (√) 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 your 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

□***Supplies Committee***: 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.

rootspcs_pac@hotmail.com

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 Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

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

Name	Date of Birth	Date / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#

GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!

Asthma Severity *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals_____
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:_____

Date of Last Flu Shot:
___/___/___

Green Zone: Go!–Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**
☐ _____, _____ puff(s) MDI **with spacer**_____ times a day
☐ _____, _____ nebulizer treatment(s)_____ times a day
☐ _____, take_____ by mouth once daily at bedtime

For asthma with exercise, ADD:
☐ _____, _____ puff(s) MDI with spacer 15 minutes before exercise

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to_____
(50%-80% of Personal Best)

☐ _____, _____ puff(s) MDI **with spacer** every _____ hours as needed

OR

☐ _____, _____ nebulizer treatment(s) every _____ hours as needed

☐ Other_____

Call your DOCTOR if you have these signs more than two times a week, *or* if your rescue medicine doesn't work!

Red Zone: EMERGENCY!–Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than _____
(Less than 50% of Personal Best)

☐ _____, ____ puff(s) MDI with spacer **every 15 minutes,** for **THREE** treatments

OR

☐ _____, ____ nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call your doctor while giving the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.

Healthcare Provider Initials:
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.

As the RESPONSIBLE PERSON:
☐ I hereby authorize a trained school employee, if available, to administer medication to the student.
☐ I hereby authorize the student to possess and self-administer medication.
☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

★ ★ ★ **Government of the District of Columbia**
Vincent C. Gray, Mayor

www.dcasthmapartnership.org

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