



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: Male Female
Last First M.I.
 Date of Birth: _____ Home #: _____ Language Spoken At Home _____
 Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____
 Home Address: _____
Number Street Apt. # State ZIP
 Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____
 Home Address: _____
Number Street Apt. # State ZIP
 Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____
 Home Address: _____
Number Street Apt. # State ZIP
 Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):
 _____ Relationship to child: _____
Last First M.I.
 Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

Last First M.I.

Last First M.I.

Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____
Date of Withdrawal: _____ **Reason:** _____



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

*DIVISION OF EARLY LEARNING
Licensing and Compliance Unit*

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)**

If my child _____, born on ____/____/____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

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

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: DC MD VA

Child's known Allergies or Physical Conditions: _____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Cell Phone

Date: _____
Month/Day/Year

Date Updated: _____
Month/Day/Year

Place in child's folder/record.



TRAVEL AND ACTIVITY AUTHORIZATION

- Special one time permission for this activity only Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

Trips in the van/automobile (facility or parent - owned)

_____ Explain planned activity - where and when

Field trips away from the facility

_____ Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devices and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

- I will allow my child to play outside the fenced area; or
 I will not allow my child to play outside the fenced area.

This authorization is valid from _____ / _____ / _____ to UNTIL DISENROLLED

 Parent/Guardian Signature

 Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.



Medication Authorization Form

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1; "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5, "A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log."

Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the following
Name of Facility

prescribed medication to my child _____ born on _____.

Name of Medication	Time/Frequency	Dosage	Effective Dates	
			From:	To:
			From:	
			To:	
			From:	
			To:	

Signature of Physician

Date

Signature of Parent/Guardian

Date

Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE.



The Child and Adult Care Food Program
Enrollment Form / Income Eligibility Statement for Children

CENTER NAME: **EMERGENT PREPARATORY ACADEMY**

FISCAL YEAR: _____

PART 1 – ENROLLMENT INFORMATION

You must complete ALL five columns of Part 1.

Name(s) of Enrolled Child(ren)	Date of Birth	Before & After Care	Circle Normal Days of Care / Print Normal Hours of Care	Circle the Meals the Child Normally Receives while in Care
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper

INCOME ELIGIBILITY INFORMATION

Please check all that apply and then fill out the parts specified.

- A member of my household receives SNAP (formerly Food Stamps) and/or TANF benefits. → Please complete Part 2 and Part 6.
- One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6.
- My household includes one or more foster children → Please complete Part 4 and Part 6.
- My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 5 and Part 6.
- My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 6 only.

PART 2 – HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

Name of Benefit Recipient	Circle One or Both (if applicable)	SNAP / TANF Case Number (required—not SSN or EBT #)
	SNAP TANF	

PART 3 – CHILD(REN) ENROLLED IN HEAD START

If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

Name of Child	Name of Child	Name of Child

PART 4 – FOSTER CHILDREN

Name of Foster Child	Households with foster children only: Write the child(ren)'s name(s) here, then skip to Part 6. Households with foster & non-foster children: Write foster child(ren)'s name(s) here. If you did not complete Part 2, you must complete Part 5 to qualify non-foster child(ren) for free/reduced-price meals. You may include foster child(ren) in Part 5 with non-foster child(ren). This makes it easier for non-foster child(ren) to qualify for free/reduced-price meals. If you choose to list the foster child(ren) in Part 5, you must report any personal income received by the foster child(ren). You do not have to report payments that you receive from the placement agency to support the foster child(ren). If you completed Part 2, skip Part 5. All complete Part 6.

PART 5 – TOTAL HOUSEHOLD INCOME – Not required if Part 2 or Part 3 is completed.

Write how much income and how frequently that amount is received: weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

List Names (First and Last) of Everyone In Your Household	Gross Income (before Taxes or Deductions) from Last Month (if none, write "0")								
	Earnings From Work Before Deductions		Alimony, Child Support, Welfare, etc.		Pensions, Retirement, Social Security, VA, etc.		Second job or any other income		
	NAME	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY
1.									
2.									
3.									
4.									
5.									

PART 6 – CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

The adult household member who fills out this form must sign below. If Part 5 is completed, the adult signing the form must provide the last four (4) digits ONLY of his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Statement on the back of this page.) **The last four digits of your SSN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you have listed a TANF or SNAP case number or are applying for Head Start or foster child(ren) only.** CERTIFICATION: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

PRINTED NAME OF PARENT / GUARDIAN	(LAST 4 DIGITS ONLY): XXX – XX – _____
SIGNATURE OF PARENT / GUARDIAN	SOCIAL SECURITY NUMBER (SSN) OF PARENT/GUARDIAN
	<input type="checkbox"/> I do not have a Social Security Number
DATE	
STREET ADDRESS, CITY, STATE , ZIP CODE	DAYTIME PHONE

PART 7 – CIVIL RIGHTS INFORMATION: ENROLLED CHILD(REN)’S ETHNICITY & RACE (OPTIONAL)

Check the ethnic and racial identity of your child(ren).

Ethnicity (mark one ethnic identity):

- Hispanic or Latino
- Not Hispanic or Latino

Race (mark one or more racial identities):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

This information is requested solely for the purpose of determining the State’s compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this Program is administered without discrimination.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. “The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.”

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. Additional protected traits can be found at <https://ohr.dc.gov/protectedtraits>. To file a complaint alleging discrimination on one of these bases, please contact the District of Columbia’s Office of Human Rights at (202) 727-4559 or <https://ohr.dc.gov/service/file-complaint>.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a case number for the Supplemental Nutrition Assistance Program (SNAP) and/or the Temporary Assistance for Needy Families (TANF) Program, submit an application on behalf of a foster child only, or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program. Verification efforts may be carried out through program reviews, audits, and investigations and may include contacting the Child and Family Services Agency to verify foster child status; contacting the Income Maintenance Administration office to confirm receipt of SNAP and/or TANF benefits; contacting employers to determine income; and/or checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY – IES CLASSIFICATION

Reimbursement classification category for foster children

Check if one or more foster children are reported on this form:

- Free

Reimbursement classification category for non-foster children

Check one classification for all non-foster children reported on this form:

- Free (TANF, SNAP, Income Eligible, Head Start)
- Reduced-price
- Paid (household income above free or reduced-price level)
- Paid (incomplete information)

Total Household Income:

If necessary, use the correct income conversion formula before adding incomes reported with different frequencies. Once total monthly income is determined, write “monthly” as the frequency and use the “monthly” column of the Income Eligibility Guidelines.

To find monthly income:

Weekly income X 4.33 / **every 2 weeks** X 2.15 / **twice a month** X 2

Total income: \$ _____ Frequency: _____

Number of household members: _____

The institution’s Determining Official **MUST** sign and date the IES to complete it. Signature of a Verifying Official is recommended.

Signature of Determining Official

Date

Signature of Verifying Official

Date

Date child(ren) withdrew or terminated: _____



EDUCATION

HEALTH TESTING REQUIREMENTS FOR CHILD DEVELOPMENT FACILITIES

FOR CHILDREN - (5A DCMR, Chapter 1, Section 130.4 and D.C. Universal Health Certificate Instructions)

Physical Examination:

A current comprehensive physical examination is required upon enrollment and prior to admission to the facility. This includes, age-appropriate screenings and up-to-date immunizations, and for each child three years of age and older, a complete oral health examination. Each examination must be performed by a licensed health care professional within one year prior to date of admission. Information must be provided on forms approved by the Mayor. Each child shall, at least annually, have a comprehensive physical examination and oral examination.

Tuberculosis (TB) Risk Assessment and Testing:

Prior to admission, and annually thereafter, parents or guardians are required to submit to the Child Development Facility (CDF) a District of Columbia Universal Health Certificate (DC UHC) with documentation of a comprehensive physical examination, inclusive of a tuberculosis exposure risk assessment. Upon recognition of high risk factors, a tuberculin skin test (TST) should be conducted.

Blood Tests for Lead Poisoning:

D.C. law requires that all children be tested for lead between 6-14 months and again between 22 and 26 months. D.C. law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to six years of age. Note: Children over six years old who regularly put non-food items (e.g., dirt, paint, etc.) in their mouth should be screened by their doctor every year and additional testing should be considered.

For more information on the yearly child health examination requirements, see the D.C. Universal Health Certificate instruction included in the licensure orientation package.

FOR CENTER EMPLOYEES, HOME PROVIDERS, RESIDENTS, AND VOLUNTEERS (5A DCMR, Chapter 1, Section 131.5)

Pre-Employment and Annual Physical Examinations:

A current pre-employment physical examination by a licensed health care practitioner is required. All persons living in a licensed child development home shall have an annual physical examination by a licensed health care practitioner. The physical examination must include written and signed documentation from the licensed health care practitioner stating that the person is free of communicable disease at the time of examination. In addition, physical examinations must include written and signed documentation from the licensed health care practitioner about any caregiver, employee, or volunteer diagnosed with a medical problem, and their capability of caring for children.

Tuberculosis (TB) Assessment and Testing:

Physical examinations must include written and signed documentation from the licensed health care practitioner that the person is free from tuberculosis at the time of examination. Tuberculosis (TB) tests (with results) must be repeated every two years, if the previous test was negative. Persons with positive test results should be promptly evaluated by a licensed health care practitioner and each following year.

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		
Home Address:		Apt:	City:		State: ZIP:
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer					
Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer					
Parent/Guardian Name:			Parent/Guardian Phone:		
Emergency Contact Name:			Emergency Contact Phone:		
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None			Insurance Name/ID #:		
Has the child seen a dentist/dental provider within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ / _____ <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight: _____ <input type="checkbox"/> LB <input type="checkbox"/> KG	Height: _____ <input type="checkbox"/> IN <input type="checkbox"/> CM	BMI: _____	BMI Percentile: _____
Vision Screening: Left eye: 20/____ Right eye: 20/____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected		<input type="checkbox"/> Wears glasses <input type="checkbox"/> Referred <input type="checkbox"/> Not tested			
Hearing Screening: (check all that apply)		<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested <input type="checkbox"/> Uses Device <input type="checkbox"/> Referred			

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

- | | | |
|-----------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. Details provided below. |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. Details provided below. |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Language/Speech | <input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. Details provided below. |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> 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? <input type="checkbox"/> High → complete skin test and/or Quantiferon test <input type="checkbox"/> Low	Skin Test Date:	Quantiferon Test Date:	
	Skin Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative <input type="checkbox"/> Positive, CXR Positive <input type="checkbox"/> Positive, Treated	Quantiferon Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> 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	1 st Test Date:	1 st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1 st Serum/Finger Stick Lead Level:
	2 nd Test Date:	2 nd Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	2 nd 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: _____

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.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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).	<input type="checkbox"/>	<input type="checkbox"/>		
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.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant ?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need)	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have pain, abscess, or swelling? (Urgent care need)	<input type="checkbox"/>	<input type="checkbox"/>		
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			
	<input type="text"/> <input type="text"/>			
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			
	<input type="text"/> <input type="text"/>			
Q8 What type of dental insurance does the patient have?	Medicaid	Private Insurance	Other	None
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.