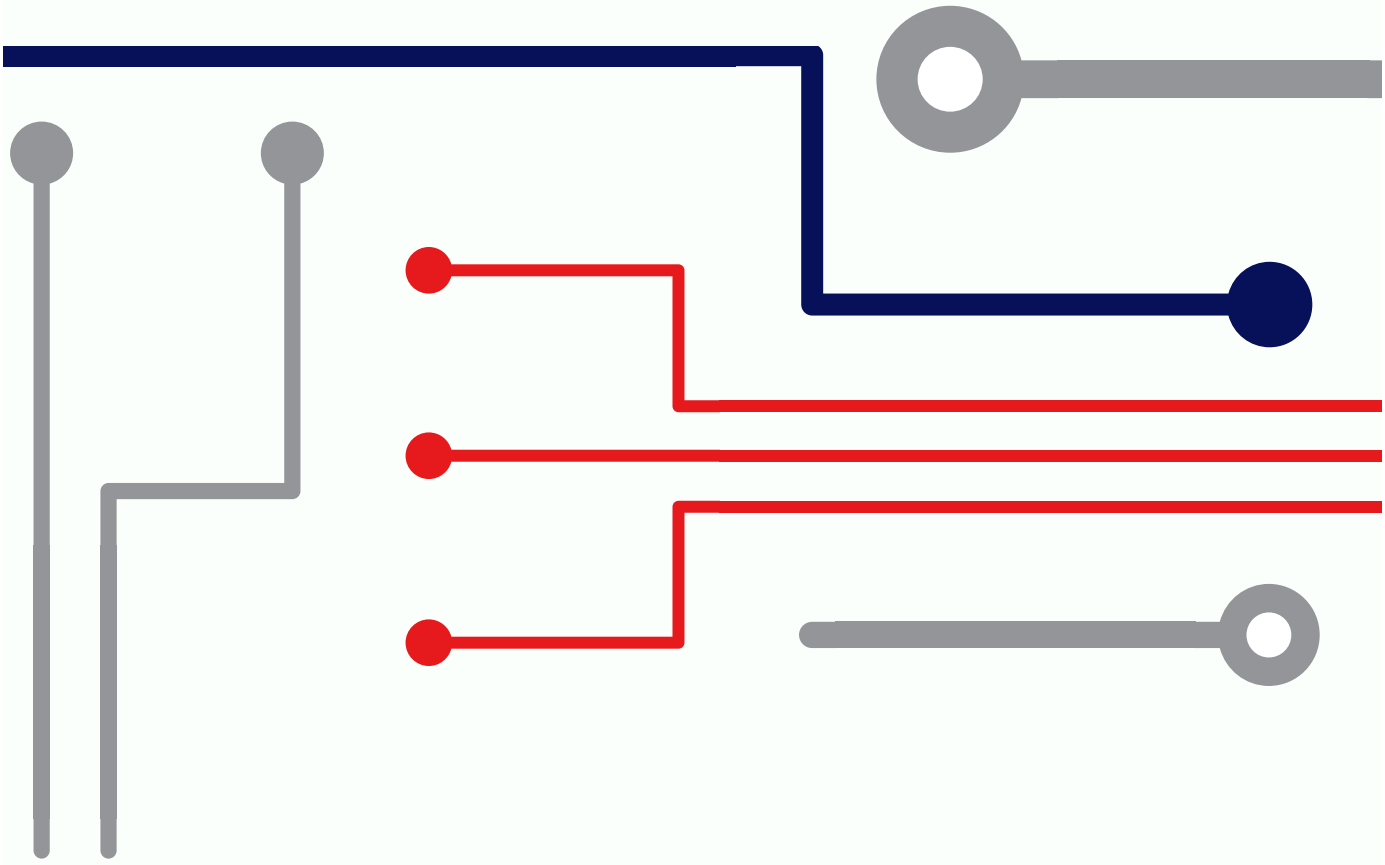
Howard University Middle School of Mathematics and Science

ENROLLMENT PACKET

SCHOOL YEAR 2017-2018



Student Name _____

SY 2017 - 2018 Grade _____

405 Howard Place, NW - Washington, DC 20059 - 202-806-7725 (Office) - 202-865-0271 (Fax) - https://hu-ms2.org

ENROLLMENT DOCUMENT CHECKLIST

_____ _____

CHILD'S NAME- PRINT SY 17-18 GRADE

FORMS/DOCUMENTS (Please place a check by each document that has been submitted)

- ☐ [1]MySchoolDC Enrollment Form
- ☐ [2]Home Language Survey
- ☐ [3]DC Residency Verification
- ☐ [4]Proof of Legal Guardian's Identity (Any state issued Photograph ID).
- ☐ [5]Copy of Student's Birth Certificate
- ☐ [6]Student's most recent Report Card
- ☐ [7]District of Columbia Universal Health Certificate*
- ☐ [8]District of Columbia Oral Health Assessment Form*
- ☐ [9]Individual Education Plan, IEP *(if applicable)*

Completed enrollment packets are due by May 1, 2017 by 4:30 pm.

*Medical Forms (# 7-8) and Lunch Forms are due by August 19, 2016.

Note: Failure to submit any of the required documents included in this checklist by the due date will result in your child's place at $(MS)^2$ being forfeited and offered to the next student on our waitlist via My School DC. The submission of fraudulent information or the withholding of information can result in the revocation of this offer of enrollment.

MY SCHOOL DC
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MySchoolDC.org

ENROLLMENT FORM
2017-18 School Year

Parents/Guardians: Please complete this form to confirm your child's enrollment in a My School DC school.

Student Information ***You must fill out one form for each child you are enrolling.**

First Name:	*MI:*	*Application Tracking #:*
Last Name:	*Date of Birth:* ____/____/____ MONTH DAY YEAR	
Current School (2016-17):	*Current Grade (2016-17):*	
Enrolling School (2017-18):	*Enrolling Grade (2017-18):*	

Parent/Guardian Information ***Should be the person completing the form and confirming residency.**

First Name:	*Last Name:*	
Address:		
City:	*State:*	*Zip:*

Records Release ***Please check the *required* box below so that the enrolling school can request your child's records.**

☐ I hereby authorize the enrolling school to request records from the current school for the student above. I also hereby authorize the enrolling school to request records from any other previous schools that the student above has attended. I understand that the enrolling school will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation ***Please read and check each box below to confirm your enrollment for 2017-18.***

☐ I understand that by submitting this form, I am confirming the enrollment of the student above in the enrolling school for 2017-18.

☐ I understand that I cannot maintain enrollment at more than one school for 2017-18.

☐ I understand that once this form is submitted, I will give up my space at my current school for next school year (2017-18) and my current school will be notified that my space may be awarded to another family.

☐ I understand that if I enroll as a result of receiving a waitlist offer from this school that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Parent/Guardian Signature:	Date: ____/____/____ MONTH DAY YEAR

THIS SECTION IS TO BE COMPLETED BY STAFF AT THE ENROLLING SCHOOL

Date Received: ____/____/_____ **Time Received: _____** **Printed Staff Name: _____** **Staff Signature: _____**	**School Seal (if applicable):**

MY SCHOOL DC
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FORMULARIO DE INSCRIPCIÓN año escolar 2017-18

Padres/Tutores: Favor de completar este formulario para confirmar la matricula de su hijo/a en una escuela participante de My School DC, la lotería escolar para las escuelas públicas de DC y las escuelas públicas independientes (chárter) de DC.

Datos del estudiante ***Necesita completar un formulario para cada niño/a al cual tiene que inscribir.**

Primer nombre:	*Segundo nombre:*	*Su número de seguimiento:*
Apellido:	*Fecha de nacimiento:* ____/____/____ (mes / día / año)	
Escuela actual (2016-17):	*Grado actual (2016-17):*	
Escuela de inscripción (2017-18):	*Grado de inscripción (2017-18):*	

Información del Padre/Tutor ***Debe ser la persona completando el formulario y confirmando la residencia en el Distrito de Columbia.**

Primer nombre:	*Apellido:*	
Dirección:		
Ciudad:	*Estado:*	*Código postal:*

Pedido de registros ***Se requiere que marque la siguiente casilla para que la escuela de inscripción pueda solicitar los registros del niño/a.**

☐ Por la presente autorizo a la escuela de inscripción a solicitar los registros de la escuela actual del estudiante nombrado. También por este medio autorizo a la escuela de inscripción a solicitar los registros de cualquier otra escuela al cual el estudiante ha asistido anteriormente. Entiendo que la escuela de inscripción no puede transferir ni comunicar los registros a cualquier otra parte o agencia sin mi autorización por escrito, excepto bajo la autoridad de la Ley de Privacidad de los Derechos Educativos de la Familia (FERPA por sus siglas en inglés) (20 U.S.C. § 1232g; 34 CFR Parte 99).

Confirmación de inscripción ***Favor de leer y marcar las casillas siguientes para confirmar su inscripción para el año escolar 2017-18.**

☐ Entiendo que al enviar este formulario, estoy confirmando la matrícula del estudiante nombrado en la escuela de inscripción para el año escolar 2017-18.

☐ Entiendo que no puedo matricular al estudiante nombrado en más de una escuela para el año escolar 2017-18.

☐ Entiendo que mediante esta forma, estoy revocando mi inscripción en mi escuela actual para el año escolar 2017-18 y que mi escuela actual será notificada que puede otorgar mi espacio a otra familia.

☐ Entiendo al aceptar la oferta de la lista de espera e inscribir a mi hijo/a en esta escuela se le removerá de todas las listas de espera de las escuelas clasificadas por debajo de esta escuela en mi solicitud de My School DC.

Firma de Padre/Tutor:	**Fecha: ____/____/_____** (mes / día / año)

ESTA SECCIÓN SERÁ COMPLETADA POR PERSONAL ESCOLAR

Date Received: ____/____/_____ **Time Received: _____** **Printed Staff Name: _____** **Staff Signature: _____**	**School Seal (if applicable):**

Office of the
State Superintendent of Education

OSSE Home Language Survey (HLS) Form

Complete this Home Language Survey at the Student's initial enrollment in a District of Columbia School.

This form must be signed and dated by the Parent or Guardian. This form must be kept in the student's file.

School: _____ **Student ID #:** _____

Student's Last Name: _____ **Student's First Name** _____

English

1. **Is a language other than English spoken in your home?**
   ☐ No ☐ Yes _____ **(specify language)**
2. **Does your child communicate in a language other than English?**
   ☐ No ☐ Yes _____ **(specify language)**
3. **What is your relationship to the child?**
   ☐ Father ☐ Mother ☐ Guardian ☐ Other (specify)_____

If the answer to question 1 or 2 is Yes, the law requires your child's English language proficiency to be assessed.

REGISTRAR PROCESS:

- If a parent/guardian does not speak English and your school does not have staff that speaks the parent/guardian's language, please use the Language Line for communication (1-800-752-6096).
- If the HLS indicates a language other than English is spoken in the home, then further assessment must be conducted to determine the student's English-language proficiency level.

Español (Spanish)

1. **¿Se habla otro idioma que no sea el inglés en su casa?**
   ☐ No ☐ Sí _____(idioma)
2. **¿Habla el estudiante un idioma que no sea el inglés?**
   ☐ No ☐ Sí _____(idioma)
3. **¿Cuál es su relación con el estudiante?**
   ☐ Padre ☐ Madre ☐ Guardián ☐ Otro (especifique)_____

Si la respuesta a la pregunta 1 ó 2 es "Sí", la ley requiere que se evalúe la fluidez de su hijo/a en el idioma inglés.

Français (French)

1. **Parlez-vous une langue autre que l'anglais à la maison ?**
   ☐ Non ☐ Oui _____ **(spécifiez la langue)**
2. **Votre enfant communique-t-il dans une langue autre que l'anglais ?**
   ☐ Non ☐ Oui _____ **(spécifiez la langue)**
3. **Quel est votre relation avec l'enfant ?**
   ☐ Père ☐ Mère ☐ Tuteur ☐ Autre (spécifiez) _____

Si la réponse à la question 1 ou 2 est Oui, la loi exige que les compétences de votre enfant en anglais soit évaluées.

中文 (Chinese)

1. 您家庭中是否使用不是英语的另外一种语言?
   ☐ 否 ☐ 是 _____ (请指明语言)
2. 您的孩子会使用不是英语的另一种语言交流吗?
   ☐ 不会 ☐ 会 _____ (请指明语言)
3. 您和孩子的关系是什么?
   ☐ 父亲 ☐ 母亲 ☐ 监护人 ☐ 其它(请指明) _____

如果第一或第二项问题的答案为"是"，法律要求评估您孩子的英语熟练能力（English language proficiency）。

Tiếng Việt (Vietnamese)

1 **Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?**
   ☐ Không ☐ Có _____ **(xin ghi rõ ngôn ngữ nào)**
2 **Con em quý vị có nói một ngôn ngữ nào khác ngoài tiếng Anh không?**
   ☐ Không ☐ Có _____ **(xin ghi rõ ngôn ngữ nào)**
3. **Xin cho biết liên hệ của quý vị với con em?**
   ☐ Cha ☐ Mẹ ☐ Giám hộ ☐ Liên hệ khác (xin ghi rõ)

_____

Nếu trả lời của câu hỏi 1 hoặc 2 là Có, luật lệ đòi hỏi con em quý vị phải được thẩm định trình độ thông thạo Anh ngữ.

አማርኛ (Amharic)

1. በቤትዎ ውስጥ ከእንግሊዘኛ ሌላ የሚነገር ቋንቋ አለ ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
2. ልጅዎ ከእንግሊዘኛ ሌላ የሚነጋገርበት ሌላ ቋንቋ አለ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
3. ለልጁ ያለዎት ዝምድና ምንድን ነው?
   ☐ አባት ☐ እናት ☐ አሳዳጊ ☐ ሌላ_____ (ይግለጹ)

ለጥያቄ 1 ወይም 2 መልስዎ አዎን ከሆነ፡ የልጅዎ የእንግሊዘኛ ቋንቋ ቅልጥፍና ችሎታው ደረጃ እንዲገመገም ህጉ ያዛል።

School Official's Comments:

_____ _____

Signature of School Official **Date** **Signature of Parent/Guardian** **Date**

Name of LEA/School

FORM 1 - DC RESIDENCY VERIFICATION FORM

Part A. Parent/Guardian/Caregiver or Adult Student Confirmation

I am the ☐ parent/guardian ☐ other primary caregiver ☐ adult student who is enrolling_____in school.
(Adult Student/Student Full Name)

I, the parent/guardian/caregiver or adult student, affirm that I reside at the following address:

Street | City, State | Zip Code

Part B. Parent/Guardian/Caregiver or Adult Student Sworn Statement of DC Residency

I understand that enrollment of the above named student in District of Columbia public schools or public charter schools, or other schools providing educational services funded by the District of Columbia, is based on my representation of bona fide DC residency, including this sworn statement of physical presence and my presentation of residency verification documentation. If this sworn statement is false, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school. Additionally, I understand that, under D.C. Code §38-312, any person who knowingly supplies false information to a public official in connection with student residency verification shall be subject to payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both a fine and imprisonment. I hereby waive my rights to confidentiality of information relative to my residence and understand that the District of Columbia will use whatever legal means it has at its disposal to verify my residence. I also agree to notify the school of any change of residence for myself or the student within three (3) school days of such change.

(Printed Name of Parent/Guardian/Caregiver or Adult Student) (Phone Number)

(Signature of Parent/Guardian/Caregiver or Adult Student) (Date)

Part C. General Residency Verification (must be completed by school official)

The person who enrolled the student or the adult student has presented the following as proof of his/her District of Columbia residency.
Each item must contain the name of the person enrolling the student or the name of the adult student and his/her DC address along with the criteria below.

(Refer to List of Acceptable Supporting Documentation Checklist on reverse side for detailed explanations.)

(1) One of the following items:
- ____ Pay stub, issued within 45-day window.
- ____ Unexpired official documentation of financial assistance.
- ____ Certified copy of DC Tax Form-D40.
- ____ Military housing orders.
- ____ Embassy letter.

(2) Two of the following items with matching names and addresses.
- ____ Unexpired DC motor vehicle registration.
- ____ Unexpired DC driver's license or non-driver ID.
- ____ Unexpired lease with proof of payment.
- ____ Utility bill with proof of payment.

(3) If one of the following applies, no signature is required in Part B above.
- ____ There is evidence that the student is homeless and the homeless liaison has provided homeless documentation.
- ____ Child is a ward of the District of Columbia.

(4) Use only if none of the previous options apply.
- ____ The person enrolling the student or the adult student has consented to a home visit. The visit is complete and the **Home Visitation Residency Verification Form** and **Home Visitation Consent Form have been completed** to confirm residency.

I certify, under the penalties of perjury, that I have personally reviewed all the documents presented and affirm that the information represented above is true to the best of my knowledge, information, and belief. I also affirm that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies including but not limited to the DC Office of the Inspector General, DC Office of the Attorney General, etc. upon request.

School Official (Print) | School Official (Signature) | Date

List of Acceptable Supporting Documentation Checklist

Section 1 (One is needed from this list to verify residency.)

- ○ **Pay stub:** Issued within the forty-five (45) day-window immediately preceding the school's review of residency documentation, that contains the name of person enrolling the student or the name of the adult student, shows his/her current DC home address, and shows withholding of DC personal income tax for the current tax year.
- ○ **Unexpired official documentation of financial assistance from the Government of the District of Columbia:** Issued to the person enrolling the student or the adult student within the past twelve (12) months and be current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs.
- ○ **Certified copy of Form D40:** Certified by the DC Office of Tax and Revenue, with the name of person enrolling the student or the name of the adult student as evidence of payment of DC taxes for the current or most recent tax year.
- ○ **Military housing orders:** Showing the name of the person enrolling the student or the name of the adult student, and their residency or home address in DC, including but not limited to a DEERS statement or other official communication on military letterhead.
- ○ **Embassy letter:** Issued within the past twelve (12) months showing the name of the person enrolling the student or the name of the adult student, indicating that the caregiver and the dependent student or the adult student currently live on embassy property in the District of Columbia or will reside on DC property confirmed by the embassy during the relevant school year, and an official embassy seal.

Section 2 (Two are needed from this list to verify residency. The address and name on each of the items must be the same.)

- ○ Unexpired **DC motor vehicle registration** showing the name of the person enrolling the student or the name of the adult student and his/her current DC home address.
- ○ Unexpired **lease or rental agreement with proof of payment of rent**, in the name of the person enrolling the student or the name of the adult student, for a period within two (2) months immediately preceding the school's review of residency documentation, for the current DC address at which the student actually resides.
- ○ Unexpired **DC motor vehicle operator's permit** or official government issued non-driver identification in the name of the person enrolling the student or the name of the adult student showing his/her current DC home address.
- ○ **Utility bill** (***only gas, electric, and water bills are acceptable***) **with proof of payment of a bill**, from a period within the two (2) months immediately preceding the school's review of residency documentation, listing the name of the person enrolling the student or the name of the adult student and his/her current DC home address,.

Section 3 (If one of these applies, no signature is required in Part B.)

- ○ **Homeless:** There is evidence that the student is homeless and the school's homeless liaison has provided the appropriate homeless documentation.
- ○ **Ward of the District of Columbia:** Proof that child is a ward of the District of Columbia, in the form of a court order or official documentation from DC Child and Family Services Agency.

Penalty for False Information:

Any person, including any District of Columbia public school or public charter school official, who knowingly supplies false information to a public official in connection with student residency verification shall be subject to charges of tuition retroactively, and payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both fine and imprisonment, pursuant to the District of Columbia Nonresident Tuition Act, approved September 8, 1960 and amended by the District of Columbia Public Schools and Public Charter School Student Residency Fraud Prevention Amendment Act of 2012 (D.C. Code §38-312). The case of any such person may be referred by the Office of the State Superintendent of Education to the Office of the Attorney General.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information **Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐ *M* ☐ *F*	*Race/Ethnicity:* ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____
Parent or Guardian Name:	*Telephone:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

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.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:_____/_____/_____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:_____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

District of Columbia Oral Health (Dental Provider) Assessment Form

Parent/Guardian Instructions:
Part 1: Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
Part 2: By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

Part 1: Child's Personal Information (to be completed by the parent/guardian)

Child's Last Name:	Child's First & Middle Name:	Date of Birth: MM/DD/YYYY	Gender: ☐M ☐F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: ☐Home ☐Cell ☐Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: ☐Home ☐Cell ☐Work	Emergency Contact:		Telephone:
Race Ethnicity: ☐White Non-Hispanic ☐Black Non-Hispanic ☐Hispanic ☐Asia or Pacific Islander ☐Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: ☐Medicaid ☐Private Insurance ☐None ☐Other		

Part 2: Required Parent/Guardian Signatures

Parent/Guardian Release of Health Information:
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

Dental Provider Instructions:
Part 3: Indicate Circle Yes or No in finding column. For Yes, please explain in Comments Section.
Part 4 Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

Part 3: Child's Findings and Parent Recommendations (please indicate in finding column)

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	Findings	Comments
Gingival inflammation	Y N	
Plaque and/or calculus	Y N	
Abnormal gingival attachments	Y N	
Malocclusion	Y N	
Treated Dental Caries	Y N	
Untreated dental caries	Y N	☐Check box if Urgent
Sealants on permanent molars	Y N	
Cleft lip and palate	Y N	
Preventative services completed	Y N	What kinds of preventative services were completed? ☐Prophy ☐Fluoride ☐Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐is completed ☐is not completed ☐under treatment ☐refused treatment ☐no necessary.
The child has ongoing ☐urgent ☐non-urgent treatment needs and is under treatment ☐by me or ☐has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: **Phone:** **Date:**

District of Columbia Health Certificate:
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age or older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.