CONFIDENTIAL FORM- SIDE ONE ***Please review instructions on side two***

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*School or Child Care facility:*
Parent/Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward*
Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zip code:*
Race/Ethnicity: ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____				
Primary Care Provider (Medical):	*Dentist/Dental Provider:*	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider) Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants **X** - Missing teeth

● Restoration | | Non-restorable/ Extraction

1D-One surface decay **UE**- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	**Y N**	
2. Plaque and/or Calculus	**Y N**	
3. Abnormal Gingival Attachments	**Y N**	
4. Malocclusion	**Y N**	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to _____		
DDS/DMD Signature	*Print Name*	*Date*
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or 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 or guardian	
SIGNATURE of parent or guardian	*Date*

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. 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 all children 3 years of age and 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 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's Personal Information
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 coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: **Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.**
Please use key to document all findings for each tooth. An '**X'** signifies a missing tooth (teeth) with no replacement; non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.

- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. **Final Evaluation/Required Dental Provider Signature**; 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 s**ign, date, and provide required information.**

Part 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date
The parent or guardian must print, sign, and date this part. 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 requesting this document. All information will be kept confidential.

Asthma Action Plan

Name	School	DOB / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	
Additional Emergency Contact	Contact Phone	

DO NOT WRITE IN THIS SPACE

Place Patient Label Here

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) inhaler **with spacer**_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ _____ , _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid

☐ _____ , take_____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____ , _____ puff(s) inhaler with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD QUICK-RELIEF 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) inhaler **with spacer** every _____ hours as needed
Fast-acting inhaled β–agonist

OR

☐ _____ , _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled β–agonist

☐ Other_____

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

Red Zone: EMERGENCY!–Continue CONTROL & QUICK-RELIEF 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) inhaler with spacer **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

OR

☐ _____ , ____ nebulizer treatment **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

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:_____

☐ Patient/parent has doctor/clinic number at home

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of quick-relief 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.
This authorization is valid for one calendar year.
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

Adapted from NAEPP by Children's National Medical Center
Coordinated by the National Capital Asthma Coalition
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 Updated May 2011

Asthma Action Plan

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Parent/Responsible Person	Parent's Phone	
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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:
___ /___ /___

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- 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:_____

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Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

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Inhaled corticosteroid

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Call your doctor while giving the treatments.

☐ Other_____

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REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

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Stepwise Approach for Managing Asthma in Children and Adults (from 2007 NAEPP Guidelines)

Criteria apply to all ages unless otherwise indicated	IMPAIRMENT					RISK	
	Daytime Symptoms	**Nighttime Awakenings** <5 years ≥5 years	**Interference with normal activity**	**Short-acting beta-agonist use**	**FEV_1 % predicted** (n/a in age <5)	**Exacerbations requiring oral systemic corticosteroids**	
Classification of Asthma SEVERITY: TO DETERMINE *INITIATION OF* LONG-TERM CONTROL THERAPY Consider severity and interval since last exacerbation when assessing risk.							**Step**
Severe Persistent	Throughout the day	>1x/week	Often 7x/week	Extremely limited	Several x/ day	<60%	**<5:** ≥2 in 6 months OR ≥4 wheezing episodes in 1 year lasting >1 day AND risk factors for persistent asthma **5-adult:** ≥2/year	<5: **Step 3** 5-11: **Step 3 Medium-dose ICS option** *or* **Step 4** 12-adult: **Step 4** *or* **5** *All ages: Consider short course OCS*
Moderate Persistent	Daily	3-4x/ month	>1x/week but not nightly	Some	Daily	60-80%		<5: **Step 3** 5-11: **Step 3 Medium-dose ICS option** 12-adult: **Step 3** *All ages: Consider short course OCS*
Mild Persistent	>2 days/ week but not daily	1-2x/ month	3-4x/ month	Minor	>2 days/ week but not daily	>80%		**Step 2**
Intermittent	≤2 days/week	0	≤2x/ month	None	≤2 days/ week	>80%	0-1/year	**Step 1**

Classification of Asthma CONTROL: TO DETERMINE *ADJUSTMENTS* TO CURRENT CONTROL MEDICATIONS Consider severity and interval since last exacerbation and possible medication side effects when assessing risk.								**Action:** In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.
		<12 years	**12-adult**					
Very Poorly Controlled	Throughout the day	≥2x/week	≥4x/week	Extremely limited	Several times/day	<60%	**<5:** >3/year **5-adult:** ≥2/year	**Step up 1-2 steps.** Consider short course OCS. Reevaluate in 2 weeks. For side effects, consider alternate treatment.
Not Well Controlled	>2 days/ week	≥2x/ month	1-3x/week	Some	>2 days/ week	60-80%	**<5:** 2-3/year **5-adult:** ≥2/year	**Step up at least 1 step.** Reevaluate in 2-6 weeks. For side effects, consider alternate treatment.
Well Controlled	≤2 days/ week	≤1x/ month	≤2x/ month	None	≤2 days/ week	>80%	0-1/year	**Maintain current treatment.** Follow-up every 1-6 months. Consider step down if well controlled for at least 3 months.

Daily Doses of common inhaled corticosteroids	**Fluticasone** MDI (mcg)			**Budesonide** Respules (mg)			**Beclomethasone** MDI (mcg)			**Fluticasone/ Salmeterol** DPI	**Budesonide/ Formoterol** MDI
	Low	Medium	High	Low	Medium	High	Low	Medium	High		
<5 years	176	>176-352	>352	0.25-0.5	>0.5-1	>1	n/a	n/a	n/a	n/a	n/a
5-11 years	88-176	>176-352	>352	0.5	1	2	80-160	>160-320	>320	100/50 mcg 1 inhalation BID	80 mcg/4.5 mcg 2 puffs BID
12 years-adult	88-264	>264-440	>440	n/a	n/a	n/a	80-240	>240-480	>480	Dose depends on patient	Dose depends on patient

Abbreviations:
SABA: Short-acting beta-agonist
LABA: Long-acting beta-agonist
LTRA: Leukotriene-receptor antagonist
ICS: Inhaled corticosteroids
LD-ICS: Low-dose ICS
MD-ICS: Medium-dose ICS
HD-ICS: High-dose ICS
OCS: Oral corticosteroids

CRM: Cromolyn
NCM: Nedocromil
THE: Theophylline
MLK: Montelukast
ALT: Alternative

Step 1
Preferred
SABA prn

Step 2
Preferred
LD-ICS

Alternative
<5: CRM *or* MLK

5-adult: CRM, LTRA, NCM, *or* THE

Step 3
Preferred
<5: MD-ICS

5-11: ***EITHER*** LD-ICS *plus* LABA, LTRA *or* THE ***OR*** MD-ICS

12-adult: LD-ICS *plus* LABA ***OR*** MD-ICS

Alternative
12-adult: LD-ICS *plus either* LTRA, THE *or* Zileuton

Step 4
Preferred
<5: Medium-dose ICS *plus either* LABA *or* MLK

5-adult: MD-ICS *plus* LABA

Alternative
5-11: MD-ICS *plus either* LTRA *or* THE

12-adult: MD-ICS *plus either* LTRA, THE *or* Zileuton

Step 5
Preferred
<5: HD-ICS *plus either* LABA *or* MLK

5-11: HD-ICS *plus* LABA

12-adult:
High-dose ICS *plus* LABA ***AND*** consider Omalizumab for patients who have allergies

Alternative
5-11: HD-ICS *plus either* LTRA *or* THE

Step 6
Preferred
<5: HD-ICS *plus either* LABA *or* MLK *plus* OCS

5-11: HD-ICS *plus* LABA *plus* OCS

12-adult:
HD-ICS *plus* LABA *plus* OCS ***AND*** consider Omalizumab for patients who have allergies

Alternative
5-11: HD-ICS *plus either* LTRA *or* THE *plus* OCS

←— **Step down if possible** (asthma well-controlled at least 3 months)/**Step up if needed** (check adherence, technique, environment, co-morbidities) —→

Adapted from NAEPP. Please refer to individual drug prescribing information as needed.

Allergy History Form

Dear Families,

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

1) Does your child have an allergy?

2) Does your child have a food sensitivity?

3) When and how did you first become aware of the allergy or sensitivity?

4) When was the last time your child had a reaction?

5) Please describe the signs and symptoms of the reaction.

6) What medical treatment was provided and by whom?

7) If medication is required while your child is at school, a Medication Authorization Form must be completed by a licensed medical provider and parent/guardian.

8) Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

Child's name: _____

Parent or Guardian: _____ Date: _____

Print name: _____

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

The Hill
PRESCHOOL

The Hill Preschool is a non-profit corporation that provides high quality education and nurturing care for young children. The Hill Preschool also provides parent support to facilitate the growth of healthy families.

Emergency Information Form

Child's Name _____ Birth Date: _____

Address: _____

Home Phone: _____

Mother's Name: _____ Phone: (w) _____

(c) _____

Father's Name: _____ Phone: (w) _____

(c) _____

Primary Contact: Mother ___ Father ___

Authorization for Pick-up other than Parents:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Parent'(s)/Guardian'(s) Signature _____ Date _____

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FAMILY PROFILE AND DEVELOPMENTAL CHECKLIST

The purpose of this questionnaire is to assist The Hill Preschool with familiarization of you family. Please feel free to elaborate on any responses to the questions below.

Personal History

Child's name to be used at school _____

Parent's Name _____ Occupation _____

Parent's Name _____ Occupation _____

Are there any other children in your family? Yes __ No __

Name _____ Age ___ Male __ Female __

Name _____ Age ___ Male __ Female __

Is your child adopted? Yes __ No __ Does he/she know? Yes __ No __

If the subject arises how do you want us to respond?

_____

_____

Languages (s) spoken at home _____

Who speaks this language(s)? _____

Primary Caretaker _____

Has your child previously been with a nanny/in day care/or preschool? Yes __ No __

If Yes, Indicate name and date(s) _____

Health Information
Please indicate below with a check-mark if your child has had any of the diseases listed.
Measles (Big Red) __ Whooping Cough __ Mumps __ Measles (3-day) __

Chicken Pox __ Other (Please Name) _____

Has you child had any serious illness or operation? Yes __ No __
If yes, please explain.
_____
_____
Please indicate any other medical conditions.

Frequent Nausea __ Vomiting __ Asthma __ Nose Bleeds __

History of Seizures __ Frequent Ear Infections __ Sinus Problems __
For any of the conditions checked, what course of action, if the need arises, should be taken?
_____
_____

Does you child have any allergies? Yes __ No __
If yes, please explain.
_____
_____

State any special, physical, developmental needs you child has.
_____
_____

Is he/she receiving any specialized therapy? Yes __ No __
If yes, please explain. _____

Toilet Habits

Is your child toilet trained? Yes __ No __

If no, has it been attempted? Yes __ No __
If yes, can your child indicate when he/she needs to use the bathroom? Yes __ No __

Word used for urination _____
Word used for bowel movement _____

Sleeping

What time does your child go to bed? _____ Awaken? _____

Social Relationships
Has your child had experiences playing with other children? Yes __ No __
By nature is your child (please circle): Friendly Aggressive Shy Withdrawn

Comments
Is there anything else that we need to know in order to better care for your child?
_____
_____
_____

Parent Signature _____ Date _____

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I/We received a copy of the revised The Hill Preschool (THP) Parent Handbook. I/We read and understand the policies and procedures outlined and stated in the Handbook. I/We understand that the Handbook may be amended and is subject to change with or without notice. I/We agree to be bound by all the terms and conditions in the Handbook throughout the term of my/our child (ren)'s enrollment.

Child's/Children's Name(s) _____

Parent(s)/Guardian(s) _____

Parent(s)/Guardian(s) Signatures) _____

_____

Date _____

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 **MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002**

PLEASE TYPE OR PRINT

Medication Authorization Form

Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.1; "No Child Development Facility may provide medicine or treatment, with the exception of emergency first aid, to any child, unless the Facility has obtained a written medical order or prescription from the child's licensed health care practitioner and the written consent of the child's parent (s) or guardian (s)."
Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.4; "The Facility shall maintain a medication log, on a form approved by the Director, on which the Facility shall record the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication, each time any medication is administered to a child."

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

I do hereby give permission to _____ to administer the
Name of Facility
below noted prescribed medication to my child _____ born on _____.

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

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

Part II: To be completed by the Center Director or designee:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

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 Caretaker

_____, 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: _____

_____

Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ Home _____ Business _____ Pager/Cell Phone

Date: _____ Month/Day/Year Date Updated: _____ Month/Day/Year

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

Father: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Mother: _____ 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:** _____

810 First Street, NE, 4th floor, Washington, DC 20002
Phone: 202.727.1839 • Fax: 202.727.8166 • www.osse.dc.gov

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

☐ Special 1-time permission for this activity only ☐ Blanket permission for all given activities

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

_____give my permission to
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 devises 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 is to 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 _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

NOTE: Place on file in child's folder/record

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Phone: 202.727.1839 • Fax: 202.727.8166 • www.osse.dc.gov

The Hill PRESCHOOL

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Photographic Authorization Form

Child's Name _____ **Date** _____

Address_____

_____

The Hill Preschool has permission to photograph my child, _____, during school hours by Hill Preschool staff member or parent volunteer. I understand that photographs will be used in the classrooms and in marketing materials for school fairs and/or advertising in local newspapers. At no time will my child's last name be attached to a photograph, nor will photographs be sold.

Parent's/Guardian's Name _____

Parent's/Guardian's Signature _____

Date _____

The Hill Preschool 2017-2018 School Supply List

Caterpillar Class
2 complete sets of clothing (seasonably appropriate)
Diapers, labeled with your child's name
Baby wipes (1 box)
Sleeping mat (for nappers only)
1 box of zip lock bags (gallon size)
1 box of Kleenex
Comforting toy for naptime
Reusable cup (with closeable/sealable lid)
Reusable lunch box
Storage container for lunch foods with compartments for easy eating
Reusable utensils for lunch items
School t-shirt (for field trips)
Diaper Cream (with a filled out Medication Authorization Form)
Sunscreen (with a filled out Medication Authorization Form)

Butterfly Class
2 complete sets of clothing (seasonably appropriate)
Diapers, if needed, labeled with your child's name
Baby wipes (1 box)
Sleeping mat (for nappers only)
1 box of zip lock bags (gallon size)
1 box of Kleenex
Reusable cup (with closeable/sealable lid)
Reusable lunch box
Storage container for lunch foods with compartments for easy eating
Reusable utensils for lunch items
School t-shirt (for field trips)
Diaper Cream (with a filled out Medication Authorization Form)
Sunscreen (with a filled out Medication Authorization Form)

Bumblebee Class
2 complete sets of clothing (seasonably appropriate)
Diapers, if needed, labeled with your child's name
Baby wipes (1 box)
Sleeping mat (for nappers only)
1 box of zip lock bags (gallon size)
1 box of Kleenex
Comforting toy for naptime
Reusable cup (with closeable/sealable lid)
Reusable lunch box
Storage container for lunch foods with compartments for easy eating
Reusable utensils for lunch items
School t-shirt (for field trips)
Diaper Cream (with a filled out Medication Authorization Form)
Sunscreen (with a filled out Medication Authorization Form)

Grasshopper Class
2 complete sets of clothing (seasonably appropriate)
Baby wipes (1 box)
Sleeping mat (for nappers only)
1 box of zip lock bags (gallon size)
1 box of Kleenex
Reusable cup (with closeable/sealable lid)
Reusable lunch box
Storage container for lunch foods with compartments for easy eating
Reusable utensils for lunch items
School t-shirt (for field trips)
Sunscreen (with a filled out Medication Authorization Form)

Please make sure that all clothing is clearly labeled.
If your child does not own a sleeping mat, one can be purchased at school.

The Hill Preschool

Health and Safety Handbook

May 2017

Table of Contents

THE HILL PRESCHOOL'S GUIDELINES FOR OUTDOOR PLAY

- HPS believes in the value of outdoor play in helping children to develop and to maintain healthy bodies.
- The HPS playground is safely enclosed , protected from the street, and offers a variety of materials as well as shady areas.
- The Hill Preschool offers a minimum of 1hour outdoor play in the morning and 1 hour outdoor play in the afternoon, weather permitting.
- Children should come dressed in weather appropriate clothing for days with light rain, snow, ice, heat, wind, and sun.
- On days with heat or air quality warnings (Code Orange) , children will play outside as long as is comfortably possible, at least a minimum of 30 minutes in the morning and 30 minutes in the afternoon.
- On days with extreme heat or air quality (Code Red),children will remain indoors.
- Helmets must be worn when children are riding bikes both outdoors and indoors (during inclement weather). HPS will provide helmets and ensure proper sanitation.

THE HILL PRESCHOOL'S HAND WASHING POLICY

All staff members will wash their hands throughout the day. We will periodically review our hand-washing procedures to monitor them for effectiveness. Staff assist children until they can wash their hands independently. Children in the twos and threes rooms are always supervised by sight and sound when hand-washing. Children in the Grasshopper room may occasionally wash hands without direct visual and auditory supervision.

Children and adults are required to:

- Wash hands upon arrival for the day
- After diapering and toileting
- After touching bodily fluids
- Before and after meals and snacks, food prep, or handling raw food
- Before and after water play
- Before and after handling pets, animals, or surfaces where animals contact
- When moving from one classroom to another
- Before and after assisting with feeding children
- Before and after administering medication
- Before and after assisting with toileting and diapering
- Before and after handling garbage or cleaning

Proper hand-washing procedure includes:

- Using liquid soap and running water
- Rubbing hands for at least 10 seconds, including all parts of hand
- Rinsing well
- Drying hands with a paper towel
- Avoiding touching the faucet with just-washed hands
- Hand-washing and food prep should occur in separate sinks
- Hand-washing sinks should not be used to bathe children or remove fecal matter

A note on gloves:

- Wearing gloves is required when handling blood or bloody fluids that might contain blood.
- Wearing gloves is an optional supplement , but not a replacement for hand washing.

THE HILL PRESCHOOL'S SENSORY PLAY GUIDELINES

- Children wash hands before and after playing.
- Fill the sensory table with fresh potable water only .
- Children should not drink the water.
- Children should not sit in the water.
- Children with sores on hands should not play in sensory table.
- Water should be changed before a new group plays.
- Water should be drained immediately when the group is finished.

THE HILL PRESCHOOL'S SANITATION POLICY

- Soiled/ mouthed toys are placed within a bucket labeled "dirty toys".
- Toys within the "dirty toys" bucket are cleaned daily with a bleach and water solution.
- Solution bottles (bleach and water, soap and water, and plain water) are prepared daily and labeled with current date.
- Toys and surfaces are cleaned daily as needed as well as on a weekly basis.
- Items that need to be laundered such as dramatic play clothes are sent with families on a weekly basis; additional items like pillows and rugs are sent with families monthly or as needed.

THE HILL PRESCHOOL'S POLICY ON CUPS, WATER BOTTLES, AND PACIFIERS

- No water bottles are allowed on cots
- Children may not use water bottles or pacifiers while walking, crawling, running, etc.
- Water bottles and pacifiers must be taken home on a daily basis to be sterilized
- Parents must replace damaged water bottles and pacifiers in a timely manner ; students will be provided Dixie cups for beverages until a new cup or water bottle has been provided

I _____ certify that I have read and understand the Health and Safety guidelines and policies of The Hill Preschool.

_____ _____

Signature **Date**