June 2021

Dear Parents/Guardians:

Enclosed is your 2021-2022 St. Coletta Back-to-School packet. **The forms must be filled out and returned to the school prior to the start of the new school year.** It is important that all forms be filled out completely and accurately. You do not need to wait until all forms are completed before returning them to the school as we understand physical and dental appointments may not yet be scheduled.

The Emergency Care Form consists of three pages, all of which must be fully completed each year, even if there have been no changes from previously submitted forms. I have enclosed a checklist to help track the completion of each form. Families can expect to receive another packet containing additional school information (including a revised Parent Handbook and other annual notifications) in the fall. As always, if you need any individualized assistance in completing paperwork, please do not hesitate to contact us at (202) 350-8680 or email cdecker@stcoletta.org.

MEDICAL PAPERWORK (available at www.stcoletta.org\school-program\ )

ALL STUDENTS must meet immunization requirements to attend in-person. Please provide the school your child's most updated Health Certificate, immunization record, and Dental Exam documents if you have not already done so. Any student requiring medication administration or a special medical procedure during the school day must also have a Medication and Medical Procedure Treatment Plan updated by a physician annually. Medications may be mailed to the school, Attn: School Nurse, or dropped off in person at the front desk, but CANNOT be sent to the school with your child.

While these forms should be returned to school prior to the start of school, **again, please return as many of the forms as possible prior to the end of this school year** as it is difficult to process all of the paperwork when we receive it close to the start of the new school year.

Sincerely,

Catherine Decker

Assistant Principal of Admissions

St. Coletta of Greater Washington

St. Coletta of Greater Washington

ENROLLMENT/RE-ENROLLMENT CHECKLIST

There are several required registration forms that must be received by the school prior to the beginning of the school year. Below, please find a checklist to facilitate the completion of these forms.

FOR PARENT SIGNATURE

_____ Emergency Care Form (3 page form – please complete fully)

_____ Community Permission Form

_____ Parent-School Compact for 2021-2022

_____ Photographic Release Form

_____ Free and Reduced Lunch Form

MEDICAL FORMS

(REQUIRE PARENT/GUARDIAN **AND PROVIDER** SIGNATURE)

_____ Oral Health Care Certificate

_____ DC Child Health Certificate & Immunization Record

_____ Medication and Medical Procedure Treatment Plan (***Required for students with medications and/or medical procedures administered during the course of the school day***)

_____ Authorizations Feeding Tube Procedure (**Required if your student will need a g-tube feeding while at school**)

St. Coletta of Greater Washington

St. Coletta of Greater Washington

Seeing possibilities beyond disabilities

ST. COLETTA OF GREATER WASHINGTON, INC.
EMERGENCY CARE INFORMATION
2021-2022

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

Address:_____
Street **city** **state** **zip code**

Date of Birth: ___/___/___ **Country of Birth:** _____ **Gender:** ◯ **M** ◯ **F** ◯ **X** **Race (Optional):**_____

Language Spoken at Home: _____ **Email Address:** _____

Parent/Guardians' preferred language of communication:_____

Parent/Guardian 1 Name: _____
Last First

Address (if different than above): _____

Occupation/Employer: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian 2 Name: _____
Last First

Address (if different than above): _____

Occupation/Employer: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

EMERGENCY CONTACTS: In the event a parent/guardian cannot be reached, please give the name and phone number of two persons who could pick up and take your child home in a timely manner.

1) _____
Name Relationship Phone Number(s)

2) _____
Name Relationship Phone Number(s)

I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment that a physician deems necessary for the well-being of my child.

_____
Signature of Parent/Guardian Date

1901 Independence Avenue SE, Washington DC 20003
Tel:(202) 350-8680 ■ Fax: (202) 350-8699
www.stcoletta.org

ADDITIONAL INFORMATION

Student Name:_____

_____ _____

Name of Insurance Company **Name of Physician**

_____ _____

Policy/Group/Employee Number **Physician Telephone Number**

HMO Number (if applicable): _____ **Medicaid ID# (if applicable):**_____

MEDICAL INFORMATION

My child's last Tetanus (TD, dT, DTaP) shot was given on the following date: _____

My child has allergies to drug(s)/foods/other ◯ Yes ◯ No **If yes, what is your child allergic to? Please list each item:**_____

_____

If you listed allergies please explain your child's allergic reaction to each item you listed; for example, skin rash:_____

My child has asthma: ◯ Yes ◯ No **If yes, what medication is used to treat the asthma?**_____

My child has seizures: ◯ Yes ◯ No **If yes, please explain your child's seizure <u>characteristics</u> and <u>medications</u> used to control the seizures:**_____

_____

Please list all medical conditions your child has been diagnosed with and any important information that our staff and medical personnel must know about these medical conditions:_____

_____

Does your child take any medications: ◯ Yes ◯ No **If yes, please complete the following for each medication your child takes (continues to NEXT PAGE).**

<u>Medication Name</u>	**<u>Dosage Given</u>**	**<u>How Often Given</u>**	**<u>Reason Medication Given</u>**
_____	_____	_____	_____
_____	_____	_____	_____

Student Name:_____

Medication Name	**Dosage Given**	**How Often Given**	**Reason Medication Given**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

My child will need to take the following medication(s) at school: _____

_____ _____ _____. **(You must have your child's physician complete the Permission for Medication Form for any medication that will be taken at school, to include over-the-counter medications. This form can be found in your school form packet).**

St. Coletta of Greater Washington

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VIDEO/PHOTOGRAPHIC PERMISSION

Student's Name: _____

Throughout the school year, photographs may be taken, or videotapes made, of students at school. These photos may be used on social media platforms, brochures, newsletters, or other media/print sources to highlight our school program. By selecting "Yes" below, a parent/guardian grants St. Coletta permission to share pictures/videos of their student for ***publicity purposes.*** Parents/Guardians may indicate that they do not wish for their student's photo to be used for publicity purposes by selecting "No" from the options below (*note: photos will continue to be used for classroom purposes*). If you do not want your child to be photographed or videoed for any reason, please contact Catherine Decker, Assistant Principal of Admissions at (202)350-8680 ext. 1002.

Note: This form will remain on file with school and **will no longer be sent to families annually**. Parents/Guardians may, however, change the level of permission simply by requesting another copy of this form.

Please indicate level of consent by selecting one option below:

◯ **YES** -- I **do** give my permission for my child to be photographed or videotaped for *publicity purposes* and to provide his/her first name.

◯ **NO** -- I do not give my permission for my child to be photographed or videotaped for *publicity purposes.*

_____ _____

Signature of Parent/Guardian Date

* Please be advised that parents desire to take pictures/videos during special holiday or other performances. Additionally, students take a class photo each school year on our scheduled Picture Day. If you do not want your child's photograph or video taken in either circumstance, let your teacher know that you do not want your child to participate. It is reasonable to expect that parents/guardians want pictures/videos of their children performing in special activities and many students/families enjoy receiving annual class photos.

Rev: 2/2020

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PARTICIPATION IN COMMUNITY OUTINGS rev. 6/2020

Student name: _____

COMMUNITY BASED INSTRUCTION (ALL students)

Community based instruction is an integral part of the curriculum at St. Coletta. Students frequently go for walks, go to the park, or go grocery shopping. When students travel beyond the Capitol Hill neighborhood, a specific permission slip will be sent to the home. On this form, we request your permission for your student's participation in the routine outings that are part of the instructional program.

***Modes of travel may include**:* Metro, bus, school van, walking

When: During school hours

Please sign and date for permission for your child to participate in the community based instruction during the 2021-2022 school year. By signing below, you give St. Coletta permission to take the above student to the nearest hospital in the event you or an emergency contact cannot be reached in an emergency.

_____ _____

Parent signature date

CAREER-BASED TRAINING (14 years and older) rev. 4/2018

Career-based training is a primary focus on a student's transition plan within their IEP. I understand that to participate in the Career-Based Training Program my child will:

- Travel to and from various training sites.
- Travel to and from various destinations in the community for travel training purposes.
- Participate in the tasks necessary to train at each site.
- Use all forms of public and private transportation.
- Eat lunch in areas, which are in route to or within walking distance of their destinations.
- Be accompanied by a staff member.
- Participate in the tasks necessary to train at each site (including in-house sites and Coletta Collections production)

Please sign and date for permission for your child to participate in the Career-Based Training Program during the 2021-2022 school year.

_____ _____

Parent signature date

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School-Parent/Guardian Compact (SCHOOL COPY)

St. Coletta of Greater Washington and the parents/guardians of the students participating in activities, services, and programs funded by Title I, Part A of the Elementary and Secondary Education Act (ESEA) agree that this compact outlines how the responsibility for improved student achievement will be shared by all parties to build and develop a partnership that will help the students achieve.

This school-parent compact is in effect during the 2021-2022 school year.

School/Teacher Responsibilities

St. Coletta of Greater Washington will:

1. **Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating students to achieve in the school setting as follows:**
    a. Provide specialized instruction and related services to all students in accordance with their Individualized Education Program (IEP) document.
    b. Provide parents opportunities to discuss their child's achievement through participation in annual IEP meetings, mid-year parent-teacher conferences, scheduled observations and trainings pertinent to instructional activities for carryover between home and school.
    c. Provide comprehensive staff development training in the area of education to promote school-wide student achievement and IEP goal progress.

2. **Communicate with parents/guardians as follows:**
    a. Provide written communication regarding the educational program, FLS curriculum, and teaching strategies utilized through school newsletters, the parent handbook, and Open House events.
    b. Provide quarterly student progress reports and results of statewide testing, as appropriate.
    c. Provide classroom specific information and via the home-school communication book.
    d. Contact parent/guardian via phone as needed to discuss student programming, inform of upcoming events, and relay other pertinent student information.
    e. Include updated school information and showcase school-wide activities on social media platforms.

3. **Monitor and track student attendance.**
    a. The school will provide information on attendance and truancy guidelines.
    b. Attendance calls will be made when a student is absent.
    c. The school will contact parents to discuss attendance concerns and provide information on relevant resources.

4. **Provide parents/guardians opportunities for involvement in their child's achievement**
    a. Parent/teacher trainings provided by the classroom teacher and/or therapists focused on specific student skills included on their IEP.
    b. Parent trainings provided by special education teachers, therapists, and specialists on topics such as communication, behavior management, and transition planning.
    c. Opportunities to provide input for IEPs and attend mid-year parent teacher conferences.

Parent/Guardian Responsibilities

We, as parents/guardians, will support our children's learning in the following ways:

1. **Promote my child's educational progress by:**
    a. Being an active participant in the development of my child's IEP.
    b. Attending and participating in IEP and eligibility meetings.
    c. Participating in mid-year parent conferences or other meetings scheduled to discuss my child's progress.
    d. Participating in at least one Parent Training

2. **Regularly communicate with school in such areas as:**
    a. Completion of necessary school documents and permission forms so that my child can fully participate in their educational program.
    b. Inform the school and classroom teacher of any attendance issues and provide documentation as needed.
    c. Include important information pertinent to my child for the school day through their home-school communication book.
    d. Parent will inform school of circumstances that may impact the child's day-to-day functioning in the school program.

3. **Ensure that my child attends school.**
    a. I will communicate my child's absence by calling the school attendance line and provide excuses to the school in writing
    b. I will provide documentation supporting my child's absences to the school
    c. I will make efforts to schedule doctor and therapy appointments outside of my child's instructional hours

4. **Be involved in school-wide events, training opportunities offered by the school and any other parent involvement opportunities, as much as possible.**

_____ _____

Signature of School Representative/Teacher **Date**

_____ _____

Signature of Parent/Guardian **Date**

*****Return this copy to the school and retain the version titled "Parent Copy" for your records.**

School-Parent/Guardian Compact (PARENT COPY)

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    c. I will make efforts to schedule doctor and therapy appointments outside of my child's instructional hours

4. **Be involved in school-wide events, training opportunities offered by the school and any other parent involvement opportunities, as much as possible.**

*****Parent/Guardian- keep this copy for your records. The version titled "School Copy" should be returned to the school with the rest of the Back to School documents**.

INSTRUCTIONS FOR APPLYING

A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU.

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), TEMPORARY ASSISTANCE FOR NEEDY FAMILIES, OR THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS [FDPlRJ, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.
Part 2: List the case number for any household member (including adults) receiving SNAP, TANF or FDPIR benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose to.

IF NO ONE IN YOUR HOUSEHOLD GETS STATE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), OR TEMPORARY ASSSISTANCE FOR NEEDY .FAMILIES (TANF) BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.
Part 2: Skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your child's school.
Part 4: Complete only if a child in your household isn't eligible under Part 3. See instructions for All Other Households.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary if you didn't need to fill in Part 4.
Part 6: Answer this question if you choose to.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If..2!! children in the household are foster children:
Part 1: List all foster children and the school name for each child. Check the box indicating the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose to.

If some of the children in the household are foster children:
Part 1: List all household members and the name of school for each child. For any person, including children, with no Income, you must check the "No Income" box. Check the box if the child Is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for Is homeless, migrant, or a runaway check the appropriate box and call your child's school. If not, skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

- Box 1-Name: List all household members with income.
- Box 2 -Gross Income and How Often It Was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received-weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
- For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits *(VA* benefits), and disability benefits.
- Under *All Other Income,* list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not Include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self- employed, under *Earnings from Work,* report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 6: Answer this question, if you choose.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child. For any person, including children, with no income, you must check the "No Income" box.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your child's school. If not, skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

- Box 1-Name: List all household members with income.
- Box 2 -Gross Income and How Often It Was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received-weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
- For other Income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits *(VA* benefits), and disability benefits. Under *All Other Income,* list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency.
  For ONLY the self-employed, under *Earnings from Work,* report income after expenses. This is for your business, farm, or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 6: Answer, this question if you choose.

FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

PART 1: ALL HOUSEHOLD MEMBERS

Names of all household members (first, middle initial, last)	name of school for each child indicate N/A if child is not in school	check if a foster child (legal responsbility of welfare agency or court) *if all children listed below are foster children, skip to PART 5 to sign this form	Check if NO INCOME
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART 2: BENEFITS

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES **[SNAP], [FDPIR]** OR **[TANF Cash Assistance]** PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVED BENEFITS AND **SKIP TO PART 5**. **IF NO ONE RECEIVED THESE BENEFITS, SKIP TO PART 3**.

NAME: CASE NUMBER:

PART 3: IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY CHECK THE APPROPRIATE BOX AND CALL YOU CHILD'S SCHOOL

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

PART 4: TOTAL HOUSEHOLD GROSS INCOME You must tell us how much and how often

1.NAME (list only household members with income	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED			
	earnings from work before deductions	welfare, child support, alimony	pensions, retirement, social security, SSI, VA benefits	all other income
(example) Jane Smith	$199.99 /weekly	$149.99/ every other week	$99.99/monthly	$50.00/monthly

PART 5: SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. If Part 4 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (see statement on next page)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school official may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: Print name:

Date:

Address: phone number:

City: state: zip code:

last four digits of Social Security Number: ***-**- _____ ☐ I do not have a Social Security Number

PART 6: CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Choose one or more (regardless of ethnicity)

☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or Other Pacific Islander

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a Month x 24, Monthly x 12

Total Income: Per: ☐ week ☐ every 2 weeks ☐ twice a month ☐ month ☐ year:

Household size:

Categorical Eligibility:

Eligibility: Free ☐ Reduced ☐ Denied ☐

Determining Official's Signature: date:

Confirming Official's Signature: date:

Verifying Official's Signature: date:

Your children may qualify for free or reduced price meals if your household income falls at or below the limits found at this website: http://www.fns.usda.goy/cnd/ governance

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 your child 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 last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Annual Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress this issue at any time and complete the required vaccinations.

_____ _____
Signature of Parent/Guardian or Student if >18 years Date

_____
Print Name of Parent/Guardian or Student if >18 years

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-7130 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer	
Race: *(check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____ /____ ☐ NML ☐ ABNL	**Weight:** ☐ LB ☐ KG	**Height:** ☐ IN ☐ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

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

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Developmental
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle cell
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB? ☐ High → *complete skin test and/or Quantiferon test* ☐ Low	**Skin Test Date:**	**Quantiferon Test Date:**
	Skin Test Results: ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated	
	Quantiferon Results: ☐ Negative ☐ Positive ☐ Positive, Treated	
Additional notes on TB test:		

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**
HGB/HCT Test Date:		**HGB/HCT Result:**	

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

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

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.