Office of the
State Superintendent of Education

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: ______________________________ Sex: ☐ Male ☐ Female
Last First M.I

Date of Birth: ____________ Home #: ____________ Language Spoken At Home ____________

Home Address: ______________________________
Number Street Apt # State ZIP

Parent Email(s): ______________________________

Parent ______________________________ Home # ____________
Last First M.I Business # ____________

Home Address: ______________________________
Number Street Apt # State ZIP

Business Address: ______________________________
Number Street Apt # State ZIP

Parent ______________________________ Home # ____________
Last First M.I Business # ____________

Home Address: ______________________________
Number Street Apt # State ZIP

Business Address: ______________________________
Number Street Apt # State ZIP

Relative or Guardian: ______________________________ Home # ____________
Last First M.I Business # ____________

Home Address: ______________________________
Number Street Apt # State ZIP

Business Address: ______________________________
Number Street Apt # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

______________________________ Relationship to child: ____________
Last First M.I

Address: ______________________________
Number Street Apt # State ZIP Phone #

Designated individual authorized to receive child at end of session:

____
Last First M.I

____
Last First M.I

____
Last First M.I

Signature: ____________ **Relationship to child:** ____________ **Date:** ____________

TO BE COMPLETED BY THE FACILITY

Date of Admission: ____________

Date of Withdrawal: ____________ Reason: ____________

INDIVIDUALS AUTHORIZED TO RECEIVE CHILD

Designated individual authorized to receive child at end of session:

Last Middle First

Phone Number:

Address:

Number Street Apt # State ZIP

Relationship to child

Designated individual authorized to receive child at end of session

Last Middle First

Phone Number:

Address:

Number Street Apt # State

Relationship to child:

ZIP

Designated individual authorized to receive child at end of session:

Phone Number:

Middle First

Address:

Last Number Street Apt # State

Relationship to child:

ZIP

Designated individual authorized to receive child at end of session:

Phone Number:

Middle First

Address

Last Number Street Apt # State

Relationship to child

ZIP

Designated individual authorized to receive child at end of session:

Phone Number:

Middle First

Address

Last Number Street Apt # State ZIP

Relationship to child

Designated individual authorized to receive child at end of session:

Last Middle First

Phone Number:

Address

Number Street Apt # State ZIP

Relationship to child

Signature

Relationship to Child

Date

EMERGENCY CONTACTS

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address: ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address: ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address: ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child: __________
Last Middle First

Address ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Person to be contacted in case of an emergency:

______________________________ Relationship to child __________
Last Middle First

Address ______________________________
Number Street Apt # State ZIP

Phone Number: ______________________________

Signature: ______________ Relationship to child ______________ Date ______________

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 GAP Community Child Development Center, located at
Name of Facility/Caretaker

209 Upshur St NW Washington, DC 20011, 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: ____________________ Date Updated: ____________________
Month/Day/Year Month/Day/Year

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

GAP Community Child Development Center ________ 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

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

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: GAP Community Child Development Center
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

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 GAP Community Child Development Center (Name of Facility) to administer the 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 RETAIN A COPY FOR YOUR FILE

CONFIDENTIAL FORM-SIDE ONE

PLEASE REVIEW INSTRUCTIONS ON SIDE TWO

DISTRICT OF COLUMBIA CHILD HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 6 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	Telephone1 ☐ Home ☐ Cell ☐ Work	Home Address		Ward
Emergency Contact	Telephone2 ☐ Home ☐ Cell ☐ Work	City/State (if other than D C)		Zipcode
School or child care facility: GAP Community Child Development Center	☐ 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: ____/____	☐ NML ☐ ABNL	HGB / HCT (Required for Head Start)

HEALTH CONCERNS:			REFERRED or TREATED		HEALTH CONCERNS:			REFERRED or TREATED	
Dental-Oral Health	☐ None	☐ YES	☐ Referred	☐ Under Rx	Language/Speech	☐ None	☐ YES	☐ Referred	☐ Under Rx
Asthma	☐ None	☐ YES	☐ Referred	☐ Under Rx	Vision	☐ None	☐ YES	☐ Referred	☐ Under Rx
Development	☐ None	☐ YES	☐ Referred	☐ Under Rx	Hearing	☐ None	☐ YES	☐ Referred	☐ Under Rx
Behavioral/Emotional	☐ None	☐ YES	☐ Referred	☐ Under Rx	Nutrition	☐ None	☐ YES	☐ Referred	☐ Under Rx
Learning/Attention	☐ None	☐ YES	☐ Referred	☐ Under Rx	Neurologic	☐ 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, childcare, sports, or camp.
☐ NONE ☐ YES, please detail:

____

____

B. Significant allergies or health conditions that may require ***emergency medical care*** at school, childcare, camp, or sports activity.
☐ NONE ☐ YES, please detail.

____

____

C. Long-term Medications or special care requirements or accommodations.
☐ NONE ☐ YES, please detail: (Please specify medication dosage/time/administration instructions and common side effects if given at school/child care)

____

____

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 childcare activities except as noted above. **ATHLETE IS CLEARED FOR COMPETITIVE SPORTS: ☐ YES ☐ NO**

Part 3: Immunization Information: *(Please fill in or attach equivalent copy with provider signature and date)*

Vaccine					
Diphtheria-Tetanus-Pertussis (< 7 yrs)	DTP/DTaP-1	DTP/DTaP-2	DTP/DTaP-3	DTP/DTaP-4	DTP/DTaP-5
Diphtheria-Tetanus (DT <7 yrs must have P exemption) (Td >7 yrs)	DT/Td -1	DT/Td -2	DT/Td -3	DT/Td -4	DT/Td-5
Hemophilus Influenzae B (HIB)	HIB1	HIB2	HIB3	HIB4	
Hepatitis B (HBV)	HBV1	HBV2	HBV3		
Polio	OPV/IPV-1	OPV/IPV-2	OPV/IPV-3	OPV/IPV-4	
Measles-Mumps-Rubella (MMR)	MMR1	MMR2	Measles-1 ______ Measles-2 ______	Mumps-1 ______ Mumps2 ______	Rubella-1 ______ Rubella-2 ______
Varicella	VZV1	VZV2	☐ Check if hx disease Disease date ______		
Influenza (not required)	FLU-1	FLU-2	FLU-3	FLU 4	FLU-5
Pneumococcal conjugate (PCV7)	PCV7-1	PCV7-2	PCV7-3	PCV7-4	
Other					

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing If PPD Positive:

TB EXPOSURE RISKS? See reverse side for instructions	☐ HIGH→ ☐ LOW	PPD TEST DATE:	☐ NEGATIVE ☐ POSITIVE	☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** ALL POSITIVE PPD tests MUST BE Reported to T B Control 202-698-4040
LEAD EXPOSURE RISKS? See reverse side for instructions	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels MUST BE Reported to DC Division of Lead Poisoning Prevention Fax 202-535-1398	

Part 5: Required Provider Certification and Signature

Age-Appropriate Health Screening Requirements Performed Within Current Year ☐ **YES** ☐ **NO**
If NO, please explain

____

Medical Exemption From Immunization: I hereby certify that the student named above was not immunized against (disease) ______________
because (reason) ______________ (if applicable, attach serological test results). Date Exemption Expires: ______

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 6: 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, childcare, camp, or DOH

PRINT NAME	SIGNATURE	Date

Top Copy – School Nurse **2nd Copy – School** **3rd Copy – Parent** 5/17/04

This form ***replaces*** **all forms dated before February 25, 2004,** used for entry into DC Schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form, formally the Dental Appraisal Form. This form was developed by the DC Department of Health and follows American Academy Of Pediatrics (AAP) Guidelines For Child And Adolescent Health Care Birth to 21 Years Of Age. **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 Educational 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:
Parent or Guardian: Please check the box that best fits the description of the child's race or ethnicity. Please indicate the ward of your home address. List primary care provider and type of health insurance coverage. If child has no provider or 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 health history, Examination & Recommendations: To be completed by the health care provider. Please mark all relevant boxes.

- **Date of complete health exam: All children MUST have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines.** The date entered here must indicate that the child is in compliance with these requirements outlined in DC Law 6-66.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG) **HT: Child's height in either inches (IN) or centimeters (CM)**
- **BP: If child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal please provide explanation and resolution in part 2 section "A."**
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is *required* For Head Start children. Anemia screen is recommended for menstruating adolescents based on AAP guidelines. Please record level and indicate by circling HGB or HCT.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens dental-oral health, asthma, development, behavioral/emotional, learning/attention, language/speech, vision, hearing, nutrition, and "neurologic disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO "HEALTH CONCERNS" then please mark the **'None'** Box in each screen area. **SPECIAL NOTE: 'Dental-Oral Health' refers to the screening done by a primary care provider. This does not replace a comprehensive oral examination provided by a dentist. For children age three and older the health care provider must also indicate whether dentist has screened or examined the child within the last 12 months. If no, child should be referred to dentist.**

A. Please note any significant health history, conditions, communicable illness, or restrictions that may affect the activity or program **OR mark 'NONE'.**
B. Please note any significant allergies or health conditions that may require ***emergency medical care*** at the activity or program **OR mark 'NONE'**
C. Please note any long-term medications or special care requirements or accommodations **OR mark 'NONE'.** (For medications that require administration at activity or program, please specify dosage/ timing / administration instructions and common side effects of each medication)
Athlete is cleared for competitive sports based on the assessment in the AAP Preparticipation Physical Evaluation 2nd Ed. (1997): Check YES or NO. This will cover patient for ALL YEARLY PHYSICALS for competitive sports.
Part 3: Immunization Information:
All areas of this section must be completed or an equivalent form attached with the physician's or health care provider's signature.
As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised 03/21/97), the following immunizations are required. Medical exemptions from immunizations may be granted for valid reasons with proper documentation and certified and signed by the health care provider in Part 5.
DOH Immunization Program: 202-576-7130

Summary of **REQUIRED** Cumulative Number of Doses of Vaccine for PRESCHOOL aged children[1] — Doses Must Be Appropriately Spaced and Given at Appropriate Age

Age of Child	DTaP/DTP/DT/Td[2]	Polio[3]	Hib[4]	Hepatitis B	Pneumoccal[7]	MMR[5]	Varicella[6]
Less than 2 Months	0	0	0	0	0	0	0
2-3 Months	1	1	1	1	1	0	0
4-5 Months	2	2	2	2	2	0	0
6-11 Months	3	3	3	3	3	0	0
12-17 months	4	3	3 or 4	3	4	1	1
18-60 Months	4	3	3 or 4	3	4	1	1

Summary of **REQUIRED** Cumulative Number of Doses of Vaccine for Children in **GRADES KINDERGARTEN – 12**[1] — Doses Must Be Appropriately Spaced and Given at Appropriate Age

Grade Level: Grade	Grade Level: If Ungraded	DTaP/DTP/DT/Td[2]	Polio[3]	Hib[4]	Hepatitis B	MMR[5]	Varicella[6]
Kindergarten	(5 years)	5	4	Not required	3	2	1
Grades 1 & 2	(6-7 years)	5	4	Not required	3	2	1
Grades 3 - 5	(8-10 years)	5 doses or ≥ 3 doses Td	4	Not required	3	2	1
Grades 6 - 12	(11-18+ yrs)	5 doses or ≥ 3 doses Td plus 1 Td booster if 10 years since last dose	4	Not required	3	2	<13 yrs = 1 dose ≥ 13 yrs = 2 doses

All religious exemptions must be submitted to the school Principal & must be accompanied by a signed notarized statement from parent or guardian. Child care and Head Start children must obtain exemptions from child care or Head Start Director.

[2] DTaP/DTP/DT/Td: 5 doses of DTaP/DTP are required for school entry unless the fourth dose is given on or after the 4th birthday. Three (3) doses of Td required if primary series started after 7th birthday. Td booster required every 10 years.
[3] Polio: Four doses are required for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which case only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are always required to complete the primary series. Polio not routinely required for students >18 years of age.
[4] Hib: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age, however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.
[5] MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and varicella must be given on the same day or separated by at least one month.
[6] Varicella: The varicella vaccine is not required for a student who has a reliable history of disease. One dose is required for students 12 years old or younger at the time of vaccination. If students is ≥ 13 years of age at time of vaccination, 2 doses are required. MMR and varicella must be given on the same day or at least one month apart.
[7] Pneumococcal Vaccine: Recommended for all children age 2 to 23 months. The number of primary doses is determined by age series begins. The final dose in the series should be given at age >12 months. It is also recommended for certain children age 24 to 59 months.

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing:

- **TUBERCULOSIS EXPOSURE RISKS?** Please assess risk of ALL patients for **Exposure to Tuberculosis** as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2003 AAP RED BOOK page 646.* **Current DC regulations require ONE** PPD (Purified Protein Derivative) Test for all children entering child care or school, whichever comes first. PPD Test is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note date of test and mark outcome of test (negative or positive). **IF PPD IS POSITIVE,** then mark outcome of chest X-Ray (CXR) and if child was treated. **ALL POSITIVE PPD tests MUST BE Reported to DC T.B. Control at 202-698-4040.**
- **LEAD EXPOSURE RISKS?** Please assess risk of ALL patients for exposure to lead using the *AAP Statement " Screening for Elevated Blood Lead Levels" (1998)*. All children require a lead test between 9 and 12 months of age and again at 24 months of age. All children between 26 months and 6 years who have not had a lead test require at least **ONE** documented lead test unless assessed as HIGH RISK OF EXPOSURE. Please document "Date" of most recent test and "Result". Please indicate if "Pending". "Pending" results will be **valid for two months from date of testing** and will NOT exclude child from activity or program. **ALL lead tests must be reported to DC Lead Poisoning Prevention by Fax: at 202-535-1398.**

Part 5: Required Provider Certification and Signature
All information will be kept confidential. A physician or nurse practitioner must complete this part. By checking the yes box the provider certifies that the child has received age-appropriate screenings according to AAP and EPSDT guidelines within the current year. If no is checked please explain reason in space provided.
Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

- **The parent or guardian must print, sign, and date this Part.** By signing this section the parent or guardian gives permission to the health examiner or facility to share the health information on this form with the child's school, childcare, camp, DOH, or the entity requesting this document.

209 Upshur St. NW Washington, DC 20011
(202) 462-3636 | gapccc.com | info@gapccc.com

Date:

PERMISSION TO REQUEST AND WAIVER OF LIABILITY

I, hereby give permission for my child ______________________________________ to accompany GAP, Inc., the GAP Community Child Care Center, on field trips and hereby authorize GAP Inc., the GAP Community Child Care Center it's agents assigns employees or other person acting under it's directions or authority to arrange for medical or surgical care for my child an any emergency which may occur during the field trip to and from enduring the time my child is on the trip if they are unable to reach me by telephone.

I, ____ hereby release discharge and agree to hold harmless GAP Inc., the GAP Community Child Care Center it's agents assigns employees and all persons acting under it's directions or authority or in it's behalf for any or all claims, demands or liabilities arising out or in connection of the field trip.

________________________________ ________________________________

Date Signature of Parent/Guardian

I, ____ give GAP Inc., my permission to have my child's picture taken by legitimate newspaper and/or magazine i.e. The Washington Post, The Washington Times, Newsweek, Time Magazine, Howard University Community News and similar paper and magazines including mayor television channels including cable.

I, give GAP Inc., my permission to have my child's picture(s) shown on GAP's webpage, GAP's brochure, GAP's calendar, or any marketing or advertisement done by GAP Inc.

________________________________ ________________________________

Date Signature of Parent/Guardian

209 Upshur St. NW Washington, DC 20011
(202) 462-3636 | gapccc.com | info@gapccc.com

Emergency Numbers

Parent's Name: ______________________________

Home Number: ______________________________

Work Number: ______________________________

Cell Number: ______________________________

Name of Father: ______________________________

Home Number: ______________________________

Work Number: ______________________________

Cell Number: ______________________________

Important Numbers:

____

____

____

____

____

209 Upshur St. NW Washington, DC 20011
(202) 462-3636 | gapccc.com | info@gapccc.com

I, ______________________________________ have received and understand the Parent's Handbook of the GAP Community Child Development Center.

______________________________ ______________________

Parent's Signature Date

Dear Parent or Guardian:

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's center/early care and learning center/ECE center! Please fill out the *Enrollment Form/Income Eligibility Statement*. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your childcare center.

Instructions

Here are instructions to help you complete the *Enrollment Form/Income Eligibility Statement*. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill out all of the requested information. When you are finished, please return the form to your child care provider.

Part 1: If more than one child in your household is enrolled at this center, you only need to complete **one (1)** form. Please provide all of the information requested in Part 1, including the full name (as it appears on other records) of each child in your household who is enrolled at this center and each enrolled child's date of birth. If the child is in school and attends before and/or after care at this center for most of the year, circle "YES" in the box for "Before & After Care." Circle the day(s) when each child usually attends the center and write each child's usual arrival and departure time. Then, circle which meal(s) each child usually receives from the center. In addition, even if you do not complete Part 2, 3, 4 or 5, you must still print and sign your name in Part 6 and provide your home address and telephone number.

Part 2*:* If someone in your household receives benefits from the Supplemental Nutrition Assistance Program (SNAP - formerly called Food Stamps) or from Temporary Assistance to Needy Families (TANF), complete Part 2. Write the recipient's name, circle the type of benefit received, and **provide the case number**. You may circle both SNAP and TANF if the person receives both benefits. Additionally, you must complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number.

Part 3: If your child(ren) enrolled at this center participate(s) in the Head Start/Early Head Start program, complete Part 3. Write the name of each participating child in this section. In addition, you must complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number.

Part 4*:* If you are completing this form for a foster child who is the legal responsibility of a welfare agency or court, write the name(s) of the foster child(ren) in Part 4, then complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number if applying for foster child(ren) only. Do **not** complete this section if you care for a child under an informal caregiver arrangement or permanent guardianship agreement made outside of a child welfare agency or court. You may include foster children on the same form with non-foster children living in your household. Please read the form for additional instructions.

Part 5*:* Report current income for all household members. Skip this step if you completed Part 2 or Part 3. If the information above is not reported, the Enrollment Form/Income Eligibility Statement must contain the following information in Part 5: the names of **all** household members (including children enrolled at this center), the total gross income (before taxes) currently received by each household member, the frequency the amount is received, and the signature of an adult household member, and the date the form was completed. Do not include SNAP, TANF, WIC, student financial aid, or money you receive for a foster child as income. In addition, **the primary wage earner or household member who signs the form must provide the last four (4) digits of his/her social security number.** If there is no Social Security number, mark the *Check if no SSN* box.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). Part 5 of this form must include everyone in your household.

You must report the total gross income (before taxes or deductions), listed by source, that each member of your household received during the **last month**. If you usually receive overtime pay, include it. If your hours or wages were recently reduced, report your current income. For each income amount reported, specify how often that income was received – weekly, every two weeks (biweekly), twice a month (semimonthly), or once a month (monthly). If last month's income does not accurately reflect your circumstances, you may provide your usual income (with frequency) or a projection of your current annual income (specify "annual" for the frequency). You may use last year's income as a basis for making the projection if no significant changes have occurred. If so, please specify "annual" for the frequency.

If a member of your household serves in the military, you do **not** need to report money received as part of the Military Housing Privatization Initiative, Family Subsistence Supplemental Allowance, Combat Pay, or Deployment Extension Incentive Pay (DEIP). If a household member is currently deployed, report only the portion of the deployed service member's income made available to them or the household. You must include all other income and allowances when reporting gross income.

If your household's total gross income is equal to or less than the amount indicated for your household's size on the chart below, the center receives a higher level of federal reimbursement. Once this form is completed, the eligibility determination will be valid for 12 months. However, you should notify us if you or any other household member becomes unemployed and experiences loss of income. This period of unemployment may result in your household's income qualifying for a different eligibility category.

Part 6: An adult household member must sign this form. The signer promises that all information is true and complete. Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

All meals served to children under the Child and Adult Care Food Program are provided free of charge regardless of race, color, national origin, sex, age, and disability. The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex (including gender identity and sexual orientation), religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). If you require the information in an alternative format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at (202) 720-2600 (Voice or TDD). USDA is an equal opportunity provider and employer.

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

Thank you for your cooperation.

Signature of Authorized Institution Representative

FEDERAL INCOME ELIGIBILITY GUIDELINES
Effective from July 1, 2022 to June 30, 2023

Persons in Family (Household Size)	Income Frequency (How Often You Are Paid)				
	Annually	**Monthly**	**Twice per Month**	**Bi-Weekly** (every 2 weeks)	**Weekly**
1	$25,142	$2,096	$1,048	$967	$484
2	$33,874	$2,823	$1,412	$1,303	$652
3	$42,606	$3,551	$1,776	$1,639	$820
4	$51,338	$4,279	$2,140	$1,975	$988
5	$60,070	$5,006	$2,503	$2,311	$1,156

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

CENTER NAME: Gap Community Childcare Center Inc **FISCAL YEAR:** 2023

PART 1 - ENROLLMENT INFORMATION You must complete ALL five columns of Part 1.

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

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

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

PART 2 - HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS
If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

Name of Benefit Recipient	Circle One or Both (if applicable)	SNAP / TANF Case Number **(required-<u>not</u> SSN or EBT #)**
	SNAP **TANF**	

PART 3 - CHILD(REN) ENROLLED IN HEAD START If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

Name of Child	Name of Child	Name of Child

PART 4 - FOSTER CHILDREN

Name of Foster Child

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

PART 5 - TOTAL HOUSEHOLD INCOME - *Not required if Part 2 or Part 3 is completed.*
Write how much income and how frequently that amount is received : weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

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

PART 6 - CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)
The adult household member who fills out this form must sign below. If Part 5 is completed, the adult signing the form must provide the **last four (4) digits ONLY** of his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Statement on the back of this page.) **<u>The last four digits of your SSN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you have listed a TANF or SNAP case number or are applying for Head Start or foster child(ren) only. CERTIFICATION:</u>** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

PRINTED NAME OF PARENT / GUARDIAN	**(LAST 4 DIGITS ONLY):** **X X X - XX -** _ _ _ _ SOCIAL SECURITY NUMBER (SSN) OF PARENT/GUARDIAN	
SIGNATURE OF PARENT / GUARDIAN	DATE	☐ I do not have a Social Security Number
STREET ADDRESS, CITY, STATE, ZIP CODE		DAYTIME PHONE

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

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

Ethnicity (mark one ethnic identity):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more racial identities):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

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

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

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PRIVACY ACT STATEMENT

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

CENTER USE ONLY - IES CLASSIFICATION

Reimbursement classification category for foster children

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

- ☐ Free

Reimbursement classification category for non-foster children

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

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

Total Household Income:

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

To find monthly income:

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

Total income: $ ____________ Frequency: ____________

Number of household members: ____________

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

Signature of Determining Official ____________ Date ____________

Signature of Verifying Official ____________ Date ____________

Date child(ren) withdrew or terminated : ____________

State Agency Use Only: F R P

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
OSSE EDUCATION

Infant Formula and Food Notification Form

Infant's Name: ______________________ **DOB:** ______________

Child Care Provider: Gap Community Childcare Center Inc

To: Parents/Guardians of infants, birth through 11 months old

Your child's care provider participates in the Child and Adult Care Food Program (CACFP). The CACFP is administrated by the District of Columbia Office of the State Superintendent of Education and is funded by the United States Department of Agriculture (USDA). The CACFP subsidizes the cost of the healthy meals prepared and served to your infant while in care. Your provider follows the USDA Meal Pattern Requirements for Infants (see below), as age-and developmentally-appropriate for your baby.

As a participant in the CACFP, your provider must offer formula and meals to all enrolled infants and children.

USDA Meal Pattern Requirements For Infants			
Age	**Breakfast**	**Lunch or Supper**	**Snack**
0 - 5 months	4-6 fluid ounces formula *or* breast milk		4-6 fluid ounces formula *or* breast milk
6 - 11 months	6-8 fluid ounces formula *or* breast milk AND 0-2 Tbsp fruit *or* vegetable *or* both AND 0-4 Tbsp iron fortified infant cereal, meat, fish, poultry, egg yolk, cooked dry beans or peas; *or* 0-2 oz cheese; *or* 0-4 oz (volume) cottage cheese; *or* 0-4 oz or 1/2 cup of yogurt, or a combination of the above		2-4 fluid ounces formula *or* breast milk AND 0-2 Tbsp fruit *or* vegetable *or* both AND ½ slice bread; *or* 0-2 crackers; *or* 0-4 Tbsp infant cereal or ready-to-eat breakfast cereal

PARENT FORMULA REQUEST

USDA supports and encourages mothers to continue breastfeeding when returning to work or school. *You have the option to breastfeed your infant at the center, bring your own formula or breast milk, or use the provider-supplied formula*. The provider offers the formula listed below.

Name of provider-supplied formula: ______________________

Do you accept or decline the formula supplied by your provider? *(Circle one)* **ACCEPT** **DECLINE**

If you DECLINE, list the brand of formula you will provide, or breast milk, or identify if you will breastfeed on site: ______________

PARENT FOOD REQUEST

When your infant is 6 months and/or developmentally ready to eat solid foods, do you accept or decline the provider-supplied food?

(Circle one) **ACCEPT all foods** **DECLINE all foods**

Signature of Parent or Guardian: ______________________ Date: ______________

Printed Name of Parent or Guardian: ______________________

Please check the back of this form for the center to know which food items to serve to your baby.

First Foods Check-In

Age of Infant: ______________________

<u>Developmental Readiness Indicators</u>

Indicators from HealthyChildren.org by the AAP

Question	Yes	No
Can your infant sit up with little or no help? *(in a high chair or feeding seat with good head control)*	Yes: ☐	No: ☐
Does your infant open her mouth when food comes their way? *(tracking food on a spoon, reaching for food, eager to be fed)*	Yes: ☐	No: ☐
Can your infant move food from a spoon into their mouth/throat? *(swallow without choking or gagging, little to no dribbling)*	Yes: ☐	No: ☐
Has your infant doubled their birth weight? *(weighs at least 13 pounds)*	Yes: ☐	No: ☐
Have you introduced solid foods to your infant?	Yes: ☐	No: ☐

If yes, select components and list which food items you have introduced to your infant?

Components	Check below	Food items introduced
Iron-fortified infant cereal and/or grains		
Meat/meat alternates		
Fruits		
Vegetables		

If yes, are there any foods that you do <u>not</u> want the institution to serve your infant? For example: beef, carrots, strawberries.

Components	Check below	Food items to avoid
Iron-fortified infant cereal and/or grains		
Meat/meat alternates		
Fruits		
Vegetables		

Comments: