

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child:								Sex: Male	☐ Female		
	Date of Birth:	l. ası		First		Home #:		— Language S	Spoken At Ho	me	
	Home Address:					2			- F	-	
	Home Address:	N	lumber	Street					Apt #	State	ZIP
Father:								Home #			
rather,	Home Address:	Last		First		(MI		Business #			
	Home Address.	Ni	umber	Street					Apt #	State	ZIP
	Business Address:		umber	Street					Apt #	State	ZIP
Mother:								Home #			
		Last		First		MI		Business #	-		
	Home Address:	Nu	ımber	Street					Apt #	State	ZIP
	Business Address:										
		Nu	ımber	Street					Арт #	State	ZIP
Relative of	r Guardian:							Home #			
	Home Address:		Last		First		M.I	Business #			
	Home Address.	Nur	mber	Street					Apt #	State	ZIP
	Business Address:	Numb	ber	Street					Apt #	State	ZIP
Person to b	be contacted in case	of an en	nergen	cy (oth	er tha	n parent	guardian):	<u> </u>			
								Relationship	to child:		
	Address:	Last		First		M I			-		
	-	Number	Street			Apt #	State ZII		Phone #		
Designated	individual authoriz	ed to re	ceive c	hild at	end o	f session:					
9					Last		First	MI			
-					Last		First	M I			
-					Last		First	NI I			
ignature:_						Relation	ship to child:		Date:		
-7-30-00			adia litra	TO BE	COME	PLETED BY	THE FACILIT	γ			-
ate of Ada	nission:										
	hdrawal:			son:							

	160 19	201264101	ereive rund at en		DL. N. (
		Lag	Middle	Fun	Phone Number:			
	Address:	Num	ber Street			Apt #	State	ZI
	Relationship to	child						_
esignai	ed individual aut	horized to r	eceive child at en	d of session:				
					Phone Number:			
	Address:	Las	Middle	Fun		-		
	0	Numi	bei Stract			Apt #	State	Z
	Relationship to	child					27.27-20-3100	
signati	ed individual auth	orized to re						
		Last	Middle _	Funa	Phone Number:	_		
	Address:	Numb				Apt #	State	ZI
	Relationship to							
ianote	d individual auth							
nguate	a iliaividual auth	011224 10 16	cerve child at end	1 Of 202210ff.	S' ' '			
		Les	Muddie	Firm	Phone Number:			-
	Address:	Numbe				Apr v	State	ZD
	Relationship to o	child:						
ignate	d individual auth	orized to re	ceive child at end	of session:				
					Phone Number:			
	Address	Las	Viddle	Fusi	T Mone indinoer.			
	Relationship to c	Number	covic			Apt #	Suc	ZII
	Kalationship to c	Bild						-
gnated	l individual autho	rized to red	eive child at ead	of session:				
		Last	Middle	Fusi	Phone Number:	-		
	Address	Number		rwa				
	Relationship to cl	-31.4				Apt ₹	State	ZIP
gnated	individual autho	rized to rec	eive child at end	of session:				
		las	Vluidle	First	Phone Number			
	Address	₩ ₀ πiz•.	ya.xa					
	Relanonship to of		24,14			Apt #	yare	ZIP.
			***************************************					-
rbina.			Relationship to	child	Date			

				Relationship to child:		1.4
7	Lası	Middle	Firm			
Address:	Nut	mber Sareet		Apr 1	Suic	ZIP
Person to be contacte	ed in case of an e	mergency:				
				Relationship to child:		
Address	Last	Middle	First			
Address	Num	iber Street	(6)	Apt N	· Suic	217
on to be contacted	fin case of an en	nergency:			19	
				Deterioration to atild		
	Last	Middle	Fun	Relationship to child:		
Address				And A	7.00	-
	Numbe	or Server		Apr #	State	ZIP
to be contacted	in case of an em	ergency:				
				Relationship to child:		
	Last	Middle	Firm			
Address:	Number	Street		Apt #	State	209
				Relationship to child:		
Address:	Lesi	Middle	First			
Address.	Numbe	Street		Apt #	State	ZIP
						7 900 00
o be contacted	in case of an em	ergeacy:				
		,				
	Last	Middle	First	Relationship to child		
Address:						
	Numba	ોવલ્લ		Apr. 1	State	209
	2					
to be contacted in	n case of an eme	rgeacy:				
				Relationship to child:		
	Last	Middle	Fea	i consideration of the constant		
Address	Number	Social		Apr f	State	ZIP
				75-780-732		47111
to be contacted to	a assu of a a seem	Mileton School State (
to be contracted by	a caps or all sells	Renal.				
	Lea	Module	70,000	Relationship to child		
Address	Delian.	unante	Field			
The state of the state of	Muchocz	icred		Apt Y	State	ZIP
cure.		Relamonship t	o child	Date		



PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

	, born on, become cannot be contacted, I authorize the following hospital or physician t
give the emergency medical treatme	nt required:
Hospital:	
Address:	
	or:
Physician:	M.D. Telephone No:
Address:	(Allee Coule)
give permission to	Name of Fac I itspr Ca re & es
	Name of Fac 1 itspr Ca roll to er to take my child for treatment
	Relationship to Child:
Policy Number:	Coverage:
Medicaid Number:	State: DC MD VA
Child's Known Allergies or	Physical Conditions:
Signature:	Relationship to Child:
Address:	
Address: Telephone No.	Business Pager Cell Phone



PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

Special 1-time permission for this activity only	☐ Blanket permission fo	or all given a	activities
I,Name of Parent/Guardian	parent/guardian	n of	
Name of Child		give my	permission to
the following activities:	for t	my child to	participate in
Trips in the van/automobile (facility or parent -owned)			
Explain plan	ned activity — where and when		
Field trips away from the facility			
Explain plans	ned activity — where and when		
I understand that the facility will use the appropriate child resafety rules when my child is transported in a vehicle. The facility rules in an activity that would involve transportation. In addition, if the facility has planned activities ou I will allow my child to play outside the fence. I will not allow my child to play outside the fe	tside the fenced area of t	h time that i	my child is to
This authorization is valid from/	/ to	/	/
Parent/Guardian Signature	Date Signed		
NOTE: Place on file in	child's folder/record		



District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name		CAL		T 73-4	or Disk	I Condon	I Valent and The	7-1-25
		Child's First & Mid	die Name	Date	e of Birth	Gender: □ M □ F	School or Chi	ld Care facility
Parent/Guardian Name	Telephone	1: ☐ Home ☐ Cell	□ Work	Hon	ne Address:			Wa
Emergency Contact:	Telephone	2: 🗆 Home 🗆 Cell	□ Work	City	State (if other than	D.C.)		Zip code:
Race/Ethnicity White N	Von Hisponia I	7 Plack Non Lien	ania 🗖 His	nanio 🗖 A	sian or Pacific Is	landar 🗆 Otho		
Primary Care Provider (Medic	cai);	Dei	ntist/Dental Pi	rovider:		Medicaid DF		29202
						Other		
Part 2. Child's Clinica					Date of Exam			
(Please use key to docu								
	Tooth # 17	Tooth # A	Tooth # K					
2	18	В	1			Key (Check A	Appropriate)	
3	19	<u>c</u>	M		S - Sealants		X - Missing te	eth
4	20	D E	0 —	_				11 (5)
	22	F	M	-	Restoration 1D-One surface	e decay I	Non-restora UE- Unerupted	
7	23	G	Q		2D-Two surface		DE-Officialité	1 10001
8	²⁴	H	R	-	3D-Three surfa			
	26	j	T	_	4D-More than t	hree surface de	cay	
11	27							
12	28 29							
14	30							
15	31							
16 3	32							
Part 3. Clinical Finding	gs and Recom	ımendations (P	lease indi	cate in Fi	nding column)			
				1.0				
			Findings	Comme	nts			
Gingival Inflammation			Findings Y N	Comme	nts			
Gingival Inflammation Plaque and/or Calculus				Comme	nts			
. Plaque and/or Calculus	nenis		Y N	Comme	nts			
	nents		Y N Y N	Comme	nts			
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion	nenis		Y N Y N Y N	Comme	nts			
. Plaque and/or Calculus . Abnormal Gingival Attachm	nents Yes		Y N Y N Y N	Comme	nts			
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate)	□ Yes	□ No	Y N Y N Y N		nts			
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation	□ Yes ı/Required D	□ No ental Provider	Y N Y N Y N Y N Y Signature	es				
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed	□ Yes ı/Required D	□ No ental Provider	Y N Y N Y N Y N Y Signature	es	nts		Date	
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation his child has been appropriate	□ Yes ı/Required D	□ No ental Provider	Y N Y N Y N Y N Y N Y N The state of the sta	es			Date	
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation as child has been appropriate	□ Yes ı/Required D	□ No ental Provider	Y N Y N Y N Y N Y Signature	es		x)	Date	
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation his child has been appropriate osciolation dress	□ Yes ı/Required D	□ No ental Provider	Y N Y N Y N Y N Y Signature	es incomp		*)	Date	
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation his child has been appropriate osciolation dress	□ Yes I/Required D I/Y examined. Tr	□ No ental Provider eatment □ 18 con	Y N Y N Y N Y N Y Signature	es incomp			Date	
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation his child has been appropriate osciolated Signature iddress	□ Yes I/Required D Ily examined. Tr uardian Signa Health Informal	□ No ental Provider eatment □ is con tures	Y N Y N Y N Y N Y N Y Signature	es is incomp	plete. Referred to	ild's school childe		epartment of
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation art 5. Final Evaluation one art 5. Required Parent/Girect or Guardian Release of we permission to the signing the	□ Yes I/Required D Ily examined. Tr uardian Signa Health Informal	□ No ental Provider eatment □ is con tures	Y N Y N Y N Y N Y N Y Signature	es is incomp	plete. Referred to	ild's school childe		epartment of
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation art 5. Final Evaluation art 5. Required Parent/Give permission to the signing halth after NAME or parent or quartian	□ Yes I/Required D Ily examined. Tr uardian Signa Health Informal	□ No ental Provider eatment □ is con tures	Y N Y N Y N Y N Y N Y Signature	es is incomp	plete. Referred to		care camp, or Do	epartment of
Plaque and/or Calculus Abnormal Gingival Attachm Malocclusion Other (e.g. cleft lip/palate) reventive services completed art 4. Final Evaluation his child has been appropriate osciolated Signature iddress one art 5. Required Parent/Gu rent or Guardian Release of we permission to the signing halth	□ Yes I/Required D Ily examined. Tr uardian Signa Health Informal	□ No ental Provider eatment □ is con tures	Y N Y N Y N Y N Y N Y Signature	es is incomp	plete. Referred to	ild's school childe	care camp, or Do	epartment of



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

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 below noted prescribed med	Nac	ne of Facility	to administer the born on
Name of Medication	Time/Frequency	Dosage	Effective Dates
			From:
			To:
			From:
			To
•	Signature of Physician		Date
Sign	ature of Parent/Guardian	C	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



DISTRICT OF COLUMBIA CHILD HEALTH CERTIFICATE

				,,c	Date of E		of	Race/Ethnicity		1990 BANK 10-10 IS	☐ Black Non Hispan
Child's Last Name		Child's First				AA		_Hispanic/		r Islander - r	Other
Parent or Guardian Name		I olenhane I	⊓Home [7.1.011	Ноте Ас		<u>.</u>	Дунаранно Ду	TOTAL TOT T DOIN	J IGIGINOCI D	Ward
r arent or Guardian Name		/ Work	[]riume [Joen 1	nome At	00/633					Ward
Emergency Contact		1 '	Home	J Cell C	City/Stati	(if other than D.C.)			Zipcod	e
		□ Work									
School or child care facility			□Med	icaid _Priv	vate Insu	urance 🛮 Noi	16	Frima	ry Care Provid	er (PCP)	
			□ Oth	er				1			
Part 2: Child's Healt	h History	, Examinat	ion & Rec	ommendat	ions.		Hea	Ith Provider:	Form mu	st be fully	completed.
DATE OF HEALTH E	XAM:		WT	□ LBS	3 H	T	□ IN	BP:	I»Jyn³□ N		B / HCT
		- 1		□ KG			\square CM		□AE	INL (Requ	ired for Head Start)
HEALTH CO	NCEDNO:		DEEEDE	RED or TREA	TED I			CONCERNS:	-		ED or TREATED
Dental-Oral Health	□ None	☐ YES						-	□ YES		
Asthma	□ None	□ YES		ed 🗆 Under	_	Language/S Vision	Speech	☐ None	☐ YES		ed 🗆 Under Rx
Development	□ None	□ YES		ed 🗆 Under				□ None	☐ YES	1	ed 🗆 Under Rx
Behavioral/Emotional	□ None	☐ YES		ed 🗆 Under		Hearing Nutrition		□ None		111000	ed 🗆 Under Rx
				ed 🗆 Under					□ YES		
Learning/Attention	□ None	☐ YES				Neurologic	*** *	□ None	□ YES	<u> </u>	ed 🗆 Under Rx
ANNUAL DENTIST VISI											
A. Significant health	history, c	onditions, c	communic	able illness	s, or re	estrictions th	nat may	affect schoo	l, childcare	e, sports, d	or camp.
☐ NONE ☐ YES, ple	ease deta	iil:									
B. Significant allergie	es or heal	th condition	ns that ma	y require e	merg	ency medi	cal care	at school, c	hildcare, c	amp, or si	ports activity.
□ NONE □ YES, ple				, ,	J	•			•		,
31-1											
C. Long-term Medica	ations or s	special care	requirem	nents or acc	commo	odations.					
□ NONE □ YES, ple							structions	and common s	ide effects if	given at sch	ool/child care)
		(,								
										_	
This child has been a	opropriate	ely examined	d & health	history revi	iewed.						participate in all
This child has been ap					iewed. ATH	At time of	exam, th		satisfactor	y health to	participate in all ES □ NO
school, camp or childe Part 3: Immunization	care activ Informat	ities except ion: (Please	as noted	above.	ATH	At time of	exam, th	is child is in FOR COMPE	satisfactor TITIVE SPO	y health to DRTS: □ Y	ES 🗆 NO
school, camp or childe Part 3: Immunization	care activ	ities except	as noted fill in or a	above. ttach equiva	ATH	At time of HLETE IS CL	exam, th	is child is in FOR COMPE nature and date orgonals	satisfactor TITIVE SPO	y health to DRTS: □ Y	ES I NO
school, camp or child Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (1	care activ	ities except	as noted fill in or a	above.	ATH	At time of	exam, th	is child is in FOR COMPE	satisfactor TITIVE SPO	y health to DRTS: □ Y	ES 🗆 NO
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (I yrs)	care activ Informat Pertussis of <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Plexempt	as noted fill in or a	above. ttach equiva	ATH	At time of HLETE IS CL	exam, th	is child is in FOR COMPE nature and date DIPPOTARES	satisfactor TITIVE SPO	y health to DRTS: □ Y	ES I NO
school, camp or child Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (1	care activ Informat Pertussis of <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Plexempt	as noted fill in or a	above. ttach equiva	ATH	At time of HLETE IS CLODY with providing 2	exam, th	is child is in FOR COMPE nature and date DIPATHES	satisfactor TITIVE SPO	y health to DRTS: □ Y	ES I NO
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (T yrs) Hemophilus Influenza	care activ Informat Pertussis of <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Plexempt	as noted fill in or a	above. ttach equiva onyotakt birre-t	ATH	At time of HLETE IS CLODY with providing 2	exam, th	is child is in FOR COMPE nature and date of the compensation of th	satisfactor TITIVE SPO e)	y health to DRTS: □ Y	ES I NO
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus Themophilus Influenza Hepatitis B (HBV)	care activ Informat Pertussis of <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Plexempt	as noted fill in or a	above. ttach equiva one of the contract high revi covered.	ATH	At time of HLETE IS CLODY with providing 2 OTHER THE PROVIDED TO THE PROVIDED	exam, th	DIS Child is in FOR COMPE nature and date of the companies of the companie	Satisfactor TITIVE SPO e) DINOT DINOT TORRING	y health to DRTS: □ YI	ES O NO BIPOTANS OITGS
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (T Hemophilus Influenza Hepatitis B (HBV)	care activ Informat Pertussis or <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Pexempt	as noted fill in or a	above. ttach equiva onyotakt birre-t	ATH	At time of HLETE IS CLODY with providing 2	exam, th	DIFFORMATION OF THE STATE OF TH	Satisfactor, TITIVE SPC (e) DITIO 4	y health to DRTS: □ YI	ES O NO DIPOTANS DIFIES Subella-1
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (T yrs) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub	care activ Informat Pertussis or <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Pexempt	as noted fill in or a	Above. Itach equiva OTRIPIANT DITIENT HIBT HEVT OPUMPU: I	ATH	At time of HLETE IS CL Dpy with provided to 1970 Annual 2 Direct Provided Annual 2 Direct Provid	exam, th	DIFFOR COMPE CONTROL DIFFORMAN DIFFO	Satisfactor, TITIVE SPC (e) DITIO 4 TOTAL 4 TAMPE Mumps	y health to DRTS: □ YI	ES O NO BIPOTANS OITGS
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (T yrs) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub	care activ Informat Pertussis or <7 yrs mus	ities except tion: (Please (< 7 yrs) trave Pexempt	as noted fill in or a	above. ttach equiva one of the contract high revi covered.	ATH	At time of HLETE IS CLODY with providing 2 OTHER THE PROVIDED TO THE PROVIDED	exam, th	HB3 HBV3 OPV/PV-3 Measles-2 Check if hx	Satisfactor, TITIVE SPC (e) DITIO 4 TOTAL 4 TAMPE Mumps	y health to DRTS: □ YI	ES O NO DIPOTANS DIFIES Subella-1
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (^T V _r): Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella	care activ Informati Pertussis of 27 yrs mus ae B (HIB	ities except tion: (Please (< 7 yrs) trave Pexempt	as noted fill in or a	Above. Itach equiva OTRIPIANT DITIENT HIBT HEVT OPUMPU: I	ATH	At time of HLETE IS CL Dpy with provided to 1970 Annual 2 Direct Provided Annual 2 Direct Provid	exam, th	DIFFOR COMPE CONTROL DIFFORMAN DIFFO	Satisfactor, TITIVE SPC (e) DITIO 4 TOTAL 4 TAMPE Mumps	y health to DRTS: □ YI	ES O NO DIPOTANS DIFIES Subella-1
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (Upre) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require	care activ Informati Pertussis Of 7 yrs mus ae B (HIB pella (MM	ities except tion: (Please (< 7 yrs) st have P exempt	as noted fill in or a	Above. Itach equiva OTPOTANT OTPOTANT HIBI HEVT OPOTANO T	ATH	At time of HLETE IS CLOPY WITH PROPERTY OF THE PROPERTY OF T	exam, th	PIPOTAH:3 THES T	Satisfactor TITIVE SPO TOTAL TOTAL TOTAL Attempted Mumps: Cidisease	y health to DRTS: □ YI	ES O NO BIPUTANO BITOS BITOS Rubella-1 Rubella-2
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (Control of the Control of	care activ Informati Pertussis Of 7 yrs mus ae B (HIB pella (MM	ities except tion: (Please (< 7 yrs) st have P exempt	as noted fill in or a	Above. Itach equiva OTPOTANT OTPOTANT HIBT HEVT OPPOTANT VZVT	ATH	At time of HLETE IS CL DPY WITH PROVIDENT OTHER HIDZ HIDZ CHAMPY 2 MMINZ VZVZ	exam, th	PIESS HEVS CHOCK If has been a controlled by the	Satisfactor TITIVE SPO TOTAL TOTAL Attempted Mumps: Cidisease	y health to DRTS: □ YI	ES O NO BIPUTANO BITOS BITOS Rubella-1 Rubella-2
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (Tetanus) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugo Other	care activ Informati Pertussis Of 27 yrs mus ae B (HIB pella (MM	ities except tion: (Please (< 7 yrs) st have P exempt (s)	as noted e fill in or a	Above. Itach equiva OTHORIAN OTHORIAN HIBI HEVT OPOMPO: I MART VZVI FLUS PUVI-1	ATH	At time of HLETE IS CLOPY WITH POPULATION OF THE	exam, th	PIESS HEVS CHOCK If has been a controlled by the	Satisfactor TITIVE SPO TOTAL TOTAL Attempted Mumps: Cidisease	y health to DRTS: □ YI	ES O NO BIPUTANO BITOS BITOS Rubella-1 Rubella-2
school, camp or childe Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (Upre) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugo Other Part 4: Tuberculosis	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E	ities except tion: (Please (< 7 yrs) st have P exempt (s) (N) (N) (N) (N) (N) (N) (N) (N) (N) (N	as noted e fill in or a	Above. Itach equiva OTHERS FIRST OPPORT VALUE FLUS POUP Sment & Te	ATH	At time of HLETE IS CLOPY WITH POOL OF THE POOL OF T	exam, th	DIFFORM COMPERATION OF THE STATE OF THE STAT	Satisfactor TITIVE SPO OPINO Tess OPINO Alternative Mumps: disease	y health to DRTS: ☐ YI	ES O NO DIPUTANS SITIÉS. Rubella-1 Rubella-2
school, camp or childer Part 3: Immunization Diphtheria-Tetanus Tetanus Tetanu	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E	ities except tion: (Please (< 7 yrs) st have P exempt R) R) xposure Ri HIGH-	as noted e fill in or a	Above. Itach equiva OTHORIAN OTHORIAN HIBI HEVT OPOMPO: I MART VZVI FLUS PUVI-1	ATH	At time of HLETE IS CLOPY WITH PROPERTY OF THE	exam, th	PLUS CXR NEGATIVE	Satisfactor TITIVE SPO Ge) DITHOT OP-INPO Attempted Mumps: C disease	y health to DRTS: U Y	BIPOTANS OTTAS Subella-1 Rubella-2 PLD-5 Ovider: ALL POSITIVE
school, camp or childer Part 3: Immunization Diphtheria-Tetanus Tetanus Tetanu	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E	ities except tion: (Please (< 7 yrs) st have P exempt (s) (N) (N) (N) (N) (N) (N) (N) (N) (N) (N	as noted e fill in or a men) (1d >7	HIBITOPURPUTE TO THE STEEL STORES TO ATE	ATH Hent co	At time of HLETE IS CL Dpy with provided and the provided	exam, the EARED vider significant signific	THES. HES.	satisfactor, TITIVE SPO	y health to DRTS: Y	ES D NO BIPOTANS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fuphtheria-Tetanus (Temperatus Influence Hemophilus Influence Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influence (not require Pneumococcal conjugother Part 4: Tuberculosis TB EXPOSURE RISKSee reverse side for instructions LEAD EXPOSURE RISKS	care activ Informati Pertussis DI <7 yrs mus ae B (HIB Della (MM Della (MM Della (PC) & Lead E S?	ities except tion: (Please (< 7 yrs) st have P exempt R) R) xposure Ri HIGH-	as noted e fill in or a men) (1d >7	Above. Itach equiva OTHERS FIRST OPPORT VALUE FLUS POUP Sment & Te	ATH Hent co	At time of HLETE IS CLOPY WITH PROPERTY OF THE	exam, the EARED vider significant signific	DIFFORMATION COMPETED TO THE C	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	BIPOTANS OTTAS Subella-1 Rubella-2 PLD-5 Ovider: ALL POSITIVE
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus (Temperature Programme) Hemophilus Influenza (Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugother Part 4: Tuberculosis TB EXPOSURE RISKS See reverse side for instructions LEAD EXPOSURE RISKS See reverse side for instructions	care activ Information Pertussis Per	ities except tion: (Please (< 7 yrs) st have P exempt R) Xposure Ri □ HIGH→ □ LOW □ YES→ □ NO	sk Asses PPD T	HIBITOPURPUTE TO THE STEEL STORES TO ATE	ATH Hent co	At time of HLETE IS CL Dpy with provided and the provided	exam, the EARED vider significant signific	THES. HES.	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus (Temperature Programme) Hemophilus Influenza (Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugother Part 4: Tuberculosis TB EXPOSURE RISKS See reverse side for instructions LEAD EXPOSURE RISKS See reverse side for instructions	care activ Information Pertussis Per	ities except tion: (Please (< 7 yrs) st have P exempt R) Xposure Ri □ HIGH→ □ LOW □ YES→ □ NO	sk Asses PPD T	HIBITOPURPUTE TO THE STEEL STORES TO ATE	ATH Hent co	At time of HLETE IS CL Dpy with provided and the provided	exam, the EARED vider significant signific	DIFFORMATION COMPETED TO THE C	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fuphtheria-Tetanus (Temperature) Diphtheria-Tetanus (Temperature) Diphtheria-Tetanus (Temperature) Diphtheria-Tetanus (Temperature) Diphtheria (Temperature)	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E S? SKS?	ities except tion: (Please (< 7 yrs) st have P exempt R) XPOSUTE Ri □ HIGH→ □ LOW □ YES→ □ NO ication and Si	sk Asses PPD T LEAD Signature	ABOVE. Itach equiva OTHER OTHER HIGH HEVT OPURPUT ELUT POVIT EST DATE: TEST DATE	esting	At time of HLETE IS CL DPY with providing POTITION POTITION POTITION POTITION POSITIVE RESULT:	exam, the EARED vider sign	DIFFORMATION COMPETED TO THE C	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus Tetanus Te	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E S? SKS?	ities except tion: (Please (< 7 yrs) st have P exempt R) XPOSUTE Ri □ HIGH→ □ LOW □ YES→ □ NO ication and Si	sk Asses PPD T LEAD Signature	ABOVE. Itach equiva OTHER OTHER HIGH HEVT OPURPUT ELUT POVIT EST DATE: TEST DATE	esting	At time of HLETE IS CL DPY with providing POTITION POTITION POTITION POTITION POSITIVE RESULT:	exam, the EARED vider sign	DIFFORMATION COMPETED THE STATE OF THE STA	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus Tetanus Te	care activ Informat Pertussis Of 7 yrs mus ae B (HIB pella (MM pel) gate (PC) & Lead E S? SKS?	ities except tion: (Please (< 7 yrs) st have P exempt R) XPOSUTE Ri □ HIGH→ □ LOW □ YES→ □ NO ication and Si	sk Asses PPD T LEAD Signature	ABOVE. Itach equiva OTHER OTHER HIGH HEVT OPURPUT ELUT POVIT EST DATE: TEST DATE	esting	At time of HLETE IS CL DPY with providing POTITION POTITION POTITION POTITION POSITIVE RESULT:	exam, the EARED vider sign	DIFFORMATION COMPETED THE STATE OF THE STA	Satisfactor TITIVE SPO Be Be Be Be Be Be Be Be Be B	y health to DRTS: ☐ YI ap-4 Health Pr PPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus (T Departitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjug Other Part 4: Tuberculosis TB EXPOSURE RISK See reverse side for instructions LEAD EXPOSURE RISK See reverse side for instructions Part 5: Required Proving Age-Appropriate Health If NO, please explain	care activ Informat Pertussis OT <7 yrs mus ae B (HIB pella (MM pella (MM pella (PC) & Lead E S? SKS? der Certifi h Screenii	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH-> LOW LOW YES-> NO ication and s	sk Asses PPD T LEAD Signature ments Peri	Above. Itach equiva OTPOTATE BITIAT PROTE OPPOTATE TEST DATE FORMED With	esting E: F	HEVE THE SELVE THE S	exam, the EARED vider significant signific	HB3 HBV3 CPV/PV-3 RVasdes-1 Meades-2 CXR NEGATIVE CXR POSITIVE TREATED AITH Provider: AL d Poisoning Preve	Satisfactor, TITIVE SPC (e) DIFFOT A COMPANY OF A COMPAN	Health Properties To B Control of B Control	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus-F Diphtheria-Tetanus (T D	care activ Informat Pertussis OT <7 yrs mus ae B (HIB pella (MM pella (MM pella (PC) & Lead E S? SKS? der Certifi h Screenii	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH-> LOW LOW YES-> NO ication and s	sk Asses PPD T LEAD Signature ments Peri	ebove. Itach equiva OTPOTATE BITTET HBVT OPOTATE TEST DATE FORMed With y that the study	esting E: F	At time of HLETE IS OF HEETE I	exam, the EARED vider significant signific	HB3 HBV3 OPV/PV-3 Meades-2 CXR NEGATIVE CXR POSITIVE TREATED HRND MO Munized again	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health PPPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus-Fulphtheria-Tetanus (Company) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugother Part 4: Tuberculosis TB EXPOSURE RISKS See reverse side for instructions Part 5: Required Providage-Appropriate Health (Fig. 1) Medical Exemption From Decause (reason)	care activ Informat Pertussis OT <7 yrs mus ae B (HIB pella (MM pella (MM pella (PC) & Lead E S? SKS? der Certifi h Screenii	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH-> LOW LOW YES-> NO ication and s	sk Asses PPD T LEAD Signature ments Peri	Above. Itach equiva Itach equiv	esting E: F	At time of HLETE IS OF HEETE I	exam, the EARED vider significant signific	HB3 HBV3 CPV/PV-3 RVasdes-1 Meades-2 CXR NEGATIVE CXR POSITIVE TREATED AITH Provider: AL d Poisoning Preve	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health PPPD tests T B Cont	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fulphtheria-Tetanus (Control of the Control of	care activ Informat Pertussis OT <7 yrs mus ae B (HIB pella (MM pella (MM pella (PC) & Lead E S? SKS? der Certifi h Screenii	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH-> LOW LOW YES-> NO ication and s	sk Asses PPD T LEAD Signature ments Peri	Above. Itach equiva Itach equiv	esting E: F	At time of HLETE IS CL. DIFFURDATE DIFFU	exam, the EARED vider significant signific	HB3 HBV3 OPV/PV-3 Meades-2 CXR NEGATIVE CXR POSITIVE TREATED HRND MO Munized again	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health Properties:	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus-F Diphtheria-Tetanus (T Departitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjug Other Part 4: Tuberculosis TB EXPOSURE RISKSee reverse side for instructions LEAD EXPOSURE RISKSee reverse side for instructions Part 5: Required Provictions Part 5: Required Provictions Medical Exemption From the Company (T) Print Name Address	care activ Informat Pertussis OT <7 yrs mus ae B (HIB pella (MM pella (MM pella (PC) & Lead E S? SKS? der Certifi h Screenii	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH LOW LOW NO cation and sing Requirem	sk Asses PPD T LEAD Signature ments Perioder	Above. Itach equiva Itach equiv	esting E: F	At time of HLETE IS CL Opp with property of the property of th	exam, the EARED vider significant signific	HB3 HB93 HB93 HB93 HB93 HB93 HB93 HB93 H	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health PP PPD tests T B Cont UST BE Repon 2-535-1398	ES D NO BIPOTARS CITIÉS Rubella-1 Rubella-2 FLU-5 Ovider: ALL POSITIVE MUST BE Reported to rol 202-698-4040
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus-F Diphtheria-Tetanus (T D	care activ Informat Pertussis OT <7 yrs mus ae B (HIB bella (MM bella (MM bella (PC) & Lead E S? SKS? der Certifi h Screenii bom Immun tal/Guard	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH LOW LOW LOW Station and station: The	sk Asses PPD T LEAD Signature ments Perfereby certifieres (Release	HIBITOPUNPUT MINE VZVI EST DATE TEST DATE TEST DATE formed With y that the stuce (if app.	esting E: F dent na clicable MD/NP	At time of HLETE IS CL Opy with property of the property of th	exam, the LEARED vider significant signifi	HB3 HB93 HB93 HB93 HB93 HB93 HB93 HB93 H	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health Properties: Date Fax	BIPOTANS BIPOTANS BITOSS Rubella-1 Rubella-2 PEU-5 MUST BE Reported to rol 202-698-4040 ed to DC Division of
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-Fuphtheria-Tetanus-Fuphtheria-Tetanus Tetanus	care activ Informat Pertussis OT <7 yrs mus ae B (HIB bella (MM bella (MM bella (PC) & Lead E S? SKS? der Certifi h Screenii bom Immun tal/Guard	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH LOW LOW LOW Station and station: The	sk Asses PPD T LEAD Signature ments Perfereby certifieres (Release	HIBITOPUNPUT MINE VZVI EST DATE TEST DATE TEST DATE formed With y that the stuce (if app.	esting E: F dent na clicable MD/NP	At time of HLETE IS CL Opy with property of the property of th	exam, the LEARED vider significant signifi	HB3 HB93 HB93 HB93 HB93 HB93 HB93 HB93 H	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health Properties: Date Fax	BIPOTANS BIPOTANS BITOSS Rubella-1 Rubella-2 PEU-5 MUST BE Reported to rol 202-698-4040 ed to DC Division of
school, camp or childer Part 3: Immunization Diphtheria-Tetanus-F Diphtheria-Tetanus-F Diphtheria-Tetanus (Tetanus) Hemophilus Influenza Hepatitis B (HBV) Polio Measles-Mumps-Rub Varicella Influenza (not require Pneumococcal conjugother Part 4: Tuberculosis TB EXPOSURE RISKS See reverse side for instructions LEAD EXPOSURE RISKS See reverse side for instructions Part 5: Required Providage-Appropriate Health	care activ Informat Pertussis OT <7 yrs mus ae B (HIB bella (MM bella (MM bella (PC) & Lead E S? SKS? der Certifi h Screenii bom Immun tal/Guard	ities except tion: (Please (< 7 yrs) st have P exempt (s) R) xposure Ri HIGH LOW LOW LOW Station and station: The	sk Asses PPD T LEAD Signature ments Perfereby certifieres (Release	HIBITOPUNPUT MINE VZVI EST DATE TEST DATE TEST DATE formed With y that the stuce (if app.	esting E: F	At time of HLETE IS CL Opy with property of the property of th	exam, the LEARED vider significant signifi	HB3 HB93 HB93 HB93 HB93 HB93 HB93 HB93 H	satisfactor, TITIVE SPC (e) DITIO 1 DITIO 2 DITIO 2 DITIO 2 DITIO 3 D	Health Properties: Date Fax	BIPOTANS BIPOTANS BITOSS Rubella-1 Rubella-2 PEU-5 MUST BE Reported to rol 202-698-4040 ed to DC Division of

INSTRUCTIONS FOR USE-SIDE TWO

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 quardian 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.
- 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

Age	Age of Child DTaP/DTP/DT/Td2		Polio	Hib*	Flepatitis B	Pneumoccal	MMR'	Varicella"
Less than 2 Mon	2 Months 0		0	0	0	Ű	0	0
2-3 Months	onths		E	1	1	1	0	0
4-5 Months			1	2	2	2	σ	0
6-11 Months		3	3	J	3	5	0	0
12-17 months		4	3.	3 or 4	3	4	1	
			- 1			4	1	
18-60 Months	West States		TO SEE HOLDING	3 01.4	3	A PUR SURVEY		
Summary of RE	QUIRED Cumulative	4 Number of Disses of Vaccine for Children in GRADES K DTaP/DTP/DT/Td²	INDERGARTE	N – 12 ¹	3	Poses Must Be Appro	the state of the s	Given at Appropriate Ag
Summary of RE Gra			INDERGARTE Polio ³			Poses Must Be Appro	ornately Spaced and MMR ³	Given at Appropriate Ag Varicella
Summary of RE	idle Level			N – 12 ¹			the state of the s	
Summary of RE Gra Grade	de Level If Ungraded			N - 12 ¹			the state of the s	
Summary of RE Gra Grade Kindergarten	If Ungraded (5 years)			N – 12 ¹ Hib ⁴ Not required			the state of the s	

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

*Htb 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. 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

Varicum The Vaccination 2 doses are required. MMR and varicella must be given on the same day or at least one month apart.

Pheumococcal 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.
- <u>LEAD EXPOSURE RISKS?</u> 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.

Three (3) doses of Td required if primary series started after 7th birthday Td booster required 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 every 10 years

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 inixed 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

Vancella 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

Date

Signature

GAP COMMUNITY CHILD CARE CENTER

3636 16th Street, N.W.A-131

Washington, D.C. 20010 202-462-3636 202-462-5942 Fax

PERMISSION TO REQUEST AND WAIVER OF LIABILITY

I, hereby give permission for my child	
employees or other person acting under it's	munity Child Care Center it's agents assigns s directions or authority to arrange for medical ency which may occur during the field trip to
[,	hereby release discharge and
assigns employees and all persons acting u	Community Child Care Center it's agents nder it's directions or authority or in it's behalf arising out or in connection of the field trip.
Date	Signature of Parent/Guardian
,	give GAP Inc., my permission to
nave my child's picture taken by legitimate	
Washington Post, The Washington Times, University Community News and similar prelevision channels including cable.	
	y child's picture(s) shown on GAP's webpage, narketing or advertisement done by GAP Inc.
Date	Signature of Parent/Guardian

GAP Community Childcare Center 3636 16th St NW A131 Washington DC 20010 202-462-3636 202-462-5942 fax

Emergency Numbers

Name of Mother:
Home Number:
Work Number:
Cell Number:
Name of Father:
Home Number:
Work Number:
Cell Number:
Important Numbers

GAP Community Childcare Center 3636 16th Street NW A131 Washington DC 20010 (202) 462-3636 (p) (202) 462-5942 (t)

Parent's Handbook

I,	have received and understand the
Parent's Handbook of the GAP Community Child Care	
Center.	
Parent's Signature	Date