Office of the
State Superintendent of Education

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First MI

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

Home Address: _____
Number Street Apt # State ZIP

Father: _____ Home # _____
Last First MI Business # _____

Home Address: _____
Number Street Apt # State ZIP

Business Address: _____
Number Street Apt # State ZIP

Mother: _____ Home # _____
Last First MI Business # _____

Home Address: _____
Number Street Apt # State ZIP

Business Address: _____
Number Street Apt # State ZIP

Relative or Guardian: _____ Home # _____
Last First MI 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 MI

Address: _____
Number Street Apt # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____
Last First MI

_____
Last First MI

_____
Last First MI

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

Date of Withdrawal: _____ **Reason:** _____

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

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 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:

Designated individual authorized to receive child at end of session:

Last Middle First Phone Number:

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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

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

Relationship to child: _____

Last Middle First

Address: _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____

Last Middle First

Address: _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____

Last Middle First

Address _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____

Last Middle First

Address: _____

Number Street Apt # State ZIP

_____ Relationship to child: _____

Last Middle First

Address: _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____

Last Middle First

Address: _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____

Last Middle First

Address _____

Number Street Apt # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child _____

Last Middle First

Address _____

Number Street Apt # State ZIP

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 _____ (Name of Facility or Caregiver), located at _____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ☐ DC ☐ MD ☐ VA

Child's Known Allergies or Physical Conditions: _____

_____

Signature: _____ Relationship to Child: _____

Address: _____

Telephone No. _____ (Home) _____ (Business) _____ (Pager/Cell Phone)

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

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PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

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

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

_____ give my permission to
Name of Child

_____ for my child to participate in the following activities:

Trips in the van/automobile (facility or parent -owned)

_____
Explain planned activity — where and when

Field trips away from the facility

_____
Explain planned activity — where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,
☐ I will allow my child to play outside the fenced area; or _____
☐ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

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

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CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender: ☐ M ☐ F	School or Child Care facility:
Parent/Guardian Name	Telephone1: ☐ Home ☐ Cell ☐ Work	Home Address:		Ward
Emergency Contact:	Telephone2: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zip code:

Race/Ethnicity ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other _____

Primary Care Provider (Medical):	Dentist/Dental Provider:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____

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

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

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

Key (Check Appropriate)

S - Sealants

X - Missing teeth

● Restoration

| Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

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

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

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been **appropriately** examined. **Treatment** ☐ is **complete.** ☐ is incomplete. Referred to

DDS/DMD Signature	Print Name	Date
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school childcare camp, or Department of Health

PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	Date

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

Medication Authorization Form

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

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

I do hereby give permission to _____ to administer the
Name of Facility

below noted prescribed medication to my child _____ born on _____.

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

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

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

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE RETAIN A COPY FOR YOUR FILE

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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	Race/Ethnicity
			☐ M ☐ F	☐ 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	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____	Primary Care Provider (PCP)

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

DATE OF HEALTH EXAM:	WT	☐ LBS ☐ KG	HT	☐ IN ☐ CM	BP: (>3 yrs)	☐ NML ☐ ABNL	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)***

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		DTaP/DTP/DT/Td[2]	Polio[3]	Hib[4]	Hepatitis B	MMR[5]	Varicella[6]
Grade	If Ungraded						
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.

[1] 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.
[2] 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.
[3] 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.
[4] 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.
[5] 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.
[6] 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.

Signature Date

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 _____
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

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 (f)

Parent's Handbook

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

_____ _____

Parent's Signature Date