Bellas Artes Child Creativity Center

Address: 1613 Rhode Island Ave NE Washington DC 20018
Phone Number: Main Center Number(202)758-0395 / Cell Center Number (240)918-8622
E-mail: bellas.artesccc@gmail.com
Webpage: www.bellasartesfinearts.org

Child's file Checklist /Lista de Comprobación de archive del Niño

Child's Name/ Nombre del Niño/a	Age/edad	Male / Masculino		Admission Date / Fecha de Admision
Day time Care		Female / Femenino		

1.- Índice
2.- Child información sheet/Hoja de información del niño.
3.- Registration record for Child Receiving care away from Home/Registración de Matrícula para el cuidado del niño fuera de casa-DOH/OECD form.
4. Emergency contact Information form/Contactos de información de Emergencia.
5. Contract and Acknowledgment of pólices/Contrato y conocimiento de la Póliza.
6. Registration Fee and arrangement of payment/Costo de la registración y arreglo de pago.
7. Child's historical Information/Información historial del niño.
8. Getting to know your Infant/Conociendo a su infante
9. Getting to know your pre-school age child/Conociendo su niño de edad pre-escolar.
10. Travel and activity authorization/Autorización para actividad y paseos.
11. Inside use center picture consent/ Consentimiento de toma de fotos de uso interno.
12. Release Pictures Consent/Permiso para publicación fotografias.
13. Authorization to pick up Child/ Autorización para recoger el niño.
14. ASQ-3 Ages & Stages Questionnaires

Health Form/Formas de Salud

1. Child's annual Health certification with physical examination (signed by a physician) Certificado de salud y examen fisico anual del niño, firmado por un médico DOH/OECD- form.
2. Immunization record/cuadro de vacunas.
3. Authorization for Child's emergency Medical Treatment/Autorización para tratamiento Médico del Niño en caso de Emergencia-DOH/OECD- form.
4. District of Columbia Oral health (Completed by Dental Provider) 1 year old & Up Check up every 6 months
5. Food Allergy, sensibility, food preference consent /Alergias y sensibilidad a alimentos, Autorización para administrar alimentos preferidos.
6. for Medication/permiso para medicamentos.
7.- Exclusion policy/ póliza de exclusión

Child Information sheet / Hoja de Información

Picture

My name is /Mi Nombre es: ______________________

I was Born on/Yo Naci el: ______________________

I am/Yo tengo____________Month old/Meses de edad

I am/Yo tengo______________Years old/años de edad

My Family includes (I live with)/Mi familia incluye (Yo vivo con):

____

____

____

The Language I speak at home is/Idioma que hablo en casa es: ______________________

We live at/Vivimos en:

____

My e-mail is/ Mi correo electrónico es:

____

My phone Number is/ Mi número de teléfono es: ______________________

In case of emergency, contact to/En caso de emergencia contactar a:

Name/Nombre____________________________ phone/Teléfono#______________

Name/Nombre____________________________ phone/Teléfono#______________

Name/Nombre____________________________ phone/Teléfono#______________

My favorite food is/Mi comida favorite es:

____

____

Time & ounces/Tiempo y onzas

I eat at /Yo Como a las: __________ (what time/a que tiempo) Breast milk/leche de pecho_____

DISTRICT OF COLUMBIA
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: ______________________________ 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:** ______________________________

____

EMERGENCY CONTACT INFORMATION FORM
FORMA DE CONTACTO DE EMERGENCIA

This information will be extremely important in the event of an accident or medical emergency.
Esta información es extremadamente importante en caso un accidente o emergencia médica.

Please be sure to sign and date this form
Por favor asegurarse de firmar y fechar esta forma

Name/Nombre ____
Last/Apellido First/Primer nombre MI/Inicial del segundo nombre

Phone/Teléfono #:__________________________Cell/ Celular #:______________________
E-mail/Correo electrónico: ____
Address/ Dirección: ____
Street/ Calle City/Ciudad State/ estado zip code/ código postal

Primary Emergency Contact Name/ Nombre del contacto primario de emergencias
____
Last/ apellido First/ Primer Nombre

Relationship/ Relación: ____
Work Phone/Teléfono de su trabajo:_____________________Cell/ Celular: ______________
E-mail/Correo electrónico: ____

Secondary Emergency Contact Name/ Nombre del contacto secundario de emergencias
____
Last/ apellido First/ Primer Nombre

Relaionship/Relación: ____
Work Phone/Teléfono de su trabajo: ______________________Cell/ Celular: ____________
E-mail/Correo electrónico: ____
Preferred Local Hospital/ Hospital Loca Preferido: ______________________________

Insurance information/ Información del seguro:

Company/Compañía: _________________________Policy/ Póliza#: ___________________

Comments: (include any special medical or personal information you would want an emergency care provider to know_ or special contact information)
Comentarios: Incluya cualquier información medica o personal que le gustaría que el proveedor de cuidados conozca- o información de un contacto especial.

Signature/ Firma: _________________________Date/ Fecha: _________________________

Bellas Artes Child Creativity Center

Contract of the Child Care center for Families.
Contrato del Centro de Cuidado Infantil para las familias.

When signing this Contract, you are in agreement with the terms and conditions that appear in the Parent's Manual. This Contract will cover the care of you child by the period of 1 year, beginning the date in which you have signed, unless there is a note that indicates otherwise. The price may change periodically, but not during the period of the contract.

Al firmar este contrato, Usted está de acuerdo con los términos y condiciones que aparecen en el Manual de Padres. Este contrato cubrirá el cuidado de su niño(a), por el periodo de 1 año. Empezando la fecha en que usted ha firmado, al no ser que una nota indique lo contrario. La tarifa puede cambiar periódicamente pero no durante el periodo del contrato.

1.-This contract is between/Este contrato es entre:

Parent # 1 ______________________ Address/ Dirección ______________________

Telephone # trabajo / Work phone # ______________________ Cell phone#/ # de telefono celular ______________________

E-mail: ______________________

Parent # 2 ______________________ Address/Dirección ______________________

E-mail: ______________________

Telephone # trabajo/ Work phone # ______________________ Cell phone#/ # de teléfono celular ______________________

Bellas artes Chilkd Creativity Center
Center Name/Nombre de la guardería

1613 Rhode Island Ave NE Washington DC 20018
Center Address / Dirección de la guardería

BELLAS ARTES CREATIVITY CENTER

REGISTRATION FEE AND PAYMENT ARRANGMENT/ COSTO DE REGISTRACION Y ARREGLO DEL PAGO

Child's name/ Nombre de niño: ____

Birthday /Fecha de nacimiento____________ Due Day: ______________________

Registration fee/Costo de registración: $ ______ Yearly Non-refundadle-/No retornable.

Date/Fecha: ______________________

Check#/Cheque#: ____________________

Cash payment/ pago en efectivo de: $__________________ Invoice # /Factura #____________

Child care payment deposit/ Pago del depósito del cuidado del niño $ __________

Weekly child care payment/Pago semanal del cuidado del niño: $ ____________

Date/Fecha: ______________________

Check#/Cheque#: __________ Money Order/ Giro postal de dinero: $__________

Cash payment/ pago en efectivo: $_______ Zelle App: $____________________

Paying arraignments (if accepted): pay day (please check one) /Arreglo para el pago (si es aceptado) Forma de pago (por favor escoja uno)

_Weekly/Semanal -Biweekly/Cada dos semanas --Every 4 weeks/cada 4 semanas --Monthly/mensual

Additional Comments /Comentarios adicionales: Security deposit Policy /Póliza del depósito de seguridad.

You can use the security deposit only to cover the last 4 weeks of care, when your contract expires. Otherwise is not **refundable.** El depósito no es retornable puede usarse como pago de las 4 últimas semanas de cuidado infantil **cuando expira** el contrato.

______________________ Parent's name: Nombre del padre

______________________ Phone Number/Número de teléfono

______________________ Parent's Signature/Firma del padre/Madre

______________________ Parent's e-mail/Correo electrónico

Child's start date/Fecha a comenzar del niño___________ Date/ Fecha______________

Bellas Artes Child Creativity Center

Child's Historical Information/Información Histórica del niño.

All the information provided on this form is requested so I can get to know your child and help the adjustment period go a little smoother. It will all be kept confidencial. Toda la información proveída en este formulario se solicita para que pueda conocer a su hijo y ayudar al periodo de ajuste a ir un poco más suave.

Child's name/ Nombre del niño: ____________________________**Birth date/Fecha del niño:** ______

Parent's name # 1/ Nombre del padre #1: ____

Parent's name # 2/ Nombre del padre#2: ____

1. **Please check all the words that best describe your child**:
2. **Por favor compruebe todas las palabras que mejor describen su niño.**

( ) Calm/calmado ( ) Shy/tímido ( ) Excitable/nervioso ( ) Happy/Feliz ( ) sensitive/sensible
( ) Cheerful/Alegre ( ) Loud/ruidoso ( ) Quiet/callado ( ) Easily angered/ se enoja fácilmente
( ) Stubborn/terco ( ) Curious/curioso ( ) Active/ activo ( ) Destructive/destructivo
( ) Gives in easily/ accesible ( ) Jealous/celoso ( ) Bright/brillante ( ) Busy/ocupado
( ) Temper tantrums/rabietas ( ) Share well/ comparte ( ) Hyperactive/hiperactivo
( ) Slow learner/aprende despacio ( ) Contented/satisfecho ( ) Other/otro: ___________________

3. What food does your child like/ Que comidas no le gustan a su niño?

   ____

   ____

4. What food your child dislike/ Que comidas no le gustan a su niño?

   ____

   ____

5. What makes your child mad or upset/ Que le molesta a su niño? __________________________

   ____

6. How well does your child get along with other children/ Qué tan bien su hijo se lleva bien con otros niños?____

   ____

7. What do you find is the best way of handling your child/ cual es la major manera de manejar a su niño? ____

   ____

8. Are there any family rules I should be aware of/ Hay alguna regla familiar que debemos tener en cuenta ____

   ____

9. Favorite toys, games activities / Actividades juguetes y juegos preferidos?

____

   ____

10. Is your child TOILET TRAINED? **Yes /No -- Esta** su niño entrenado para usar el inodoro? **Si /No**

What words does your child use for toilet/ Que palabras usa su niño para usar el inodoro?

____

11. How does your child express anger or frustration/ Como su niño muestra enojo o frustración?

____

____

12. Does your child have any special fears? **Yes/No**---Su niño tiene miedo a algo en especial? **Yes/No**
    Explain/Explique: _______________________

13. When your child is upset, what helps to comfort Him or Her/ Cuando su niño esta molesto que le ayuda a sentirse mejor? _______________________

    ____

14. How do you discipline your child? Como disciplina su niño Explain/ Explique:

    ____

    ____

15. Has your Child been taking an afternoon nap? **Yes/No—Si/No** Esta su niño tomando una siesta diurna? if so, how long/ Si es así por cuánto tiempo? _______________________
    If not, explain why? _______________________

    ____

16. Does your child have a special toy or blanket for nap/ Su niño tiene un juguete o cobijita para su siesta? **Yes / No –Si/No** if so, what is it/Si es asi que es? _______________________

    ____

17. Special family situations/ situación especial de la Familia (such as custody specifications, problems arising from situations etc.) (Como las especificaciones de custodia, problemas derivados de situaciones etc.) **Yes / No—Si/No**

    ____

    If so, explain: _______________________
18. Anticipated adjustment problems/ Problemas anticipados de ajuste? **Yes /No—Si/No**
    If so, explain/Si es asi, explique:

    ____

19. Any disorders developmental (slow, advanced) diagnosed or suspected? **Yes / No**
    If so, explain 19. ¿Se diagnosticó o sospechó algún trastorno de desarrollo (lento, avanzado)? Si no-- Si es así, explique: _______________________

    ____
20. Has attended previous childcare? **Yes / NO**-- Asistió a cuidado infantil anteriormente? Si no
21. Any problems at previous daycare? **Yes / No** Problemas en la guardería anterior? Si no
    If so, explain/ Si es asi explique: _______________________

    ____
22. Expectation of home daycare/ Expectativa de la guardería en el hogar: -_______________-

____

____

GETTING TO KNOW YOUR INFANT (0 – 18 MONTHS)
CONOCIENDO A SU INFANTE (0 – 18 MESES)

1.-Nombre del niño/Child's name: ____

2.- Fecha de nacimiento/D.O.B.: ____________________________

Premature si/no Premature yes/ no-- 40 Semanas si/ no—40 weeks yes/no

Peso al nacer/Birth weight_____________ Nació en casa o hospital ____________

Was born at home or hospital____

3.-Humor General del niño: Es sobretodo contento/a, cólicos ________________

General Childhood Humor: / it's mostly contented, cramping ___________________

4.-Ha estado el niño/a con alguien más que no sean sus padres sí___ no____

Has the child been with someone other than their parent's yes___ no ____?

Si su respuesta es sí, con quién/ If your answer is yes, with who? ____________

5.- Le da botellas (pachas) o le da pecho a su niño/a ________________________

Give you bottles or breastfeed your child? ________________________________

¿Si usa los dos, cuando le da botellas y cuando le da pecho? _________________

If you use both, when you give bottles and when you breastfeed? _____________

6.-Como le da botella / How do you give him/her a bottle? _____________________

Temperatura ambiente/room temperature ___ warm/tibio _____ helado/cold _______

¿Si usted calienta la botella, que procedimientos usa? _________________________

If you warm the bottle, which procedures do you use? ________________________

7.-Puede su niño /a agarrar su propia botella si_____ no______

Can your child/to grab his own bottle? yes _____ no______

8. - Esta su niño/a en Formula/Leche de pecho: ___Your child is in: Formula __or breastmilk___

9.-Come su niño/a cereal para bebes si __ no__ --- Your baby eat cereal? yes ___ no___

10.- Come su niño/a comidas solidas u otras comidas para bebes: si___ no__

Eat your child solid foods or other baby foods? yes ____no ____

11. - Comidas que le gustan a su niño/ Foods that your child likes: ____________________

____

GETTING TO KNOW YOUR INFANT (0 – 18 MONTHS)
CONOCIENDO A SU INFANTE (0 – 18 MESES)

12. - Comidas que no le gustan a su niño / Foods your child dislike ____________________

____

13.- Indique la cantidad, la clase de comida y la hora en la que su niño/a regularmente come/ Indicate the amount, type of meal, and time your child regularly eats:

Desayuno/ Breakfast: ____

Almuerzo / Lunch: ____

Merienda/ Snack: ____

14.- ¿Antes de llegar, le dará una botella o el pecho a su niño? __________________

Before you arrive, you will give a bottle or breast to your child? __________________

15. - Su niño/a necesitara desayuno yes__ no__ /your child will need breakfast? yes__no__

16.- Usa su niño/a un chupete si__ no__ Use your child a pacifier? yes___ no___

17.- Necesitara su niño /a un artículo especial para dormir sí__no_

Your child will need a special sleeping item yes__no__

18.-Duerme su niño /a toda la noche? si _ no_ /Your child sleep through the night? yes__no _

19.-A qué hora se despierta su niño/a por las mañanas? ___________

What time does your child wake up in the morning? ____________

20.- A qué hora toma su niño/a siesta: por la mañana _____por la tarde______

What time does your child take a nap? _____ in the morning___ in the afternoon ______

21.- Por favor indique cualquier información importante o instrucciones especiales con respeto al cuidado de su niño/a: ____

____

Please indicate any important information or special instructions regarding your child's care:

____

____

______________ ________________________________ ______________

Firma/Signature Relación al niño/a-Child relationship Fecha/ date

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

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

PLEASE TYPE OR PRINT

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

BELLAS ARTES CHILD CREATIVITY CENTER

INSIDE USE CENTER PICTURE CONSENT
CONSENTIMIENTO DEL USO DE FOTOS ADENTRO DEL CENTRO

______ Yo doy mi permiso para que las fotografías de mi niño, puedan ser usadas en actividades del cuidado infantil como ser: en el área de cumpleaños, área de la familia, área de actividades diarias áreas de arte, casilleros, correo de padres, y mural de actividades mensuales.
La toma de fotografías es para invitar a su niño a conocerse asimismo y a su familia a través de la fotografía se incrementa el desarrollo del área cognoscitiva, lenguaje y área socioemocional.

______ Yo **No** doy mi permiso para que las fotografías de mi niño, puedan ser usadas en actividades del cuidado infantil como ser: en el área de cumpleaños, área de la familia, área de actividades diarias áreas de arte, casilleros, correo de padres y mural de actividades mensuales.
La toma de fotografías es para invitar a su niño a conocerse asimismo y a su familia a través de la fotografía se incrementa el desarrollo del área cognoscitiva, lenguaje y área socioemocional.

______________________________ ______________________________
Padre/Guardian/Parent/Guardian Fecha/Date

INSIDE USE CENTER PICTURE CONSENT
CONSENTIMIENTO DEL USO DE FOTOS ADENTRO DEL CENTRO

______ Give my permission for my child's photographs, to be used in Child Care such as being: in the birthday area, family area, activity area, daily art area, lockers, parent mail, and mural monthly activities. Taking pictures is to invite your child to also discover themselves and your family through Photography increases the development of the cognitive area, language and socio-emotional area.

______ I do not give my permission for my child's photographs, to be used in Child Care such as being: in the birthday area, family area, activity area, daily art area, lockers, parent mail, and mural monthly activities. Taking pictures is to invite your child to also discover themselves and their family through Photography increases the development of the cognitive area, language and socio-emotional area.

______________________________ ______________________________
Padre/Guardian/Parent/Guardian Fecha/Date

PHOTOGRAPHY CONSENT FORM

Bellas Artes C.C.C. sometimes takes photographs or video during normal day-to-day activities, special events, or field trips. These images may appear in school folders, on school bulletin boards, brochures, flyers & publications, on our website www.bellasartesfinearts.org or on our Facebook page. These images may also be used in local media or for promotional purposes. The photography of enrolled children and the use of images of enrolled children at Bellas Artes C.C.C. require parental permission. If you prefer that your child not be photographed or that Images of your child not be used for the said purposes; please indicate this below. It is our policy to not photograph or use images of children for which we do not have parental consent.

Please answer the following questions about the use of photographs of your child. Circle YES or NO for each question.

- May we photograph your child during normal day-to-day activities, special events, or fieldtrips?

  YES/NO

- May images of your child be used in school folders or on school bulletin boards?

  YES/NO

- May images of your child be used in the school or publications, or in video presentations that are NOT for promotional or advertisement purposes?

  YES/NO

- May images of your child be used on our website, or our Facebook page **YES/NO**

CHILD NAME: ______________________________ **PARENT NAME** : ______________

PARENT SIGNATURE: ___________________________________ **DATE** : _________

Conditions of use of images:

- We will NOT include personal name or e-mail addresses, or telephone numbers of any child or adult in an image.
- We may use images of individual or groups of children with very general labels, such as "making a craft" or "Fieldtrips." Etc.

Authorization to pick up Child (Release Information)
Autorización para recoger al niño (Liberación Información

No child may be released from Bellas Artes C.C.C. to any person other than his/her parents or other person currently designated in writing by such parent to receive the child. Those people authorized to pick-up the child needs to present photo identification each day until easily recognized by the provider.
The following persons have my permission to pick up my child from the Bellas Artes C.C.C.:

Ningún niño puede ser dado de Bellas Artes C.C.C. a otra persona que no sea su padre u otra persona actualmente designada por escrito por dicho padre para recibir al niño. Esta persona autorizada a recoger al niño necesita presentar una identificación con fotografía cada día hasta ser reconocido por el proveedor.

Las siguientes personas tienen mi permiso para recoger a mi hijo de Bellas Artes C.C.C.

Name/Nombre: ______________________________

Phone/Telefono: ____________ Relationship to child/parentesco ____________

Name/Nombre: ______________________________

Phone/Telefono: ____________ Relationship to child/parentesco ____________

Name/Nombre: ______________________________

Phone/Telefono: ____________ Relationship to child/parentesco ____________

Name/Nombre: ______________________________

Phone/Telefono: ____________ Relationship to child/parentesco ____________

I/We certify that all of the information given on this form is correct and accurate to our best knowledge.
I/we promise that I/we will notify the provider, if any or all of the information changes.

Yo / Nosotros certificamos que toda la información dada en este formulario es correcta y exacta a nuestro mejor conocimiento.
Yo / nosotros nos comprometemos a notificar al proveedor, si alguna o toda la información a cambiado.

Note: In case of emergency call us to authorize a family member/friend that is not authorized to pick up your child, don't forget to bring your ID.

Nota: en caso de emergencia llámanos para autorizar a un familiar/amigo que no está autorizado para recoger tu niño, no olvides traer una identificación.

Parent's Signature #1: ______________________ Date/Fecha: ____________
Firma del padre # 1

Parent's Signature #2: ______________________ Date/Fecha: ____________
Firma del padre #2

Provider's Signature: ______________________ Date/Fecha: ____________

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information — **Parent/Guardian:** ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐M ☐F	Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other______
Parent or Guardian Name:	Telephone: ☐Home ☐Cell ☐Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other______		Primary Care Provider (PCP):	

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

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)______ %______
HGB / HCT (Required for Head Start)	Vision Screening Right 20/____ Left 20/____	☐ Glasses ☐ Referred	Hearing Screening Pass______ Fail______ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other______	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: ________________________

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If TST Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** ALL lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

____

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: ______________________/______________________/______________ Date of Birth:____/____/______
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month__________ Year__________ Verified by:______________________ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)
HepA: (__) Meningococcal: (__) HPV: (__)

Reason:____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)
HepA: (__) Meningococcal: (__) HPV: (__)

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)

If my child ________________________________, born on ______/________/______, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: ____

Address: ____

or:

Physician: ______________________________M.D. Telephone No: ______________________________
(Area Code)

Address: ____

I give permission to ____, located at
Name of Facility or Caregiver
____, 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: ____
____

Parent/Guardian Signature: __________________________ Relationship to Child: ______________________

Address: ____

Telephone No: __________________ __________________ __________________
Home Business Cell Phone

Date: ______________________________ Date Updated: ______________________________
Month/Day/Year Month/Day/Year

Place in child's folder/record.

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

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

Instructions

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

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

First Name ______________________ Last Name ______________________ Middle Initial ______

School or Child Care Facility Name ______________________________

Student ID ______________________ Date of Birth (MMDDYYYY): ☐☐/☐☐/☐☐☐☐

Current Gender Identity: ______________________

Home Address: ______________________ Home State: ____ Home Zip Code ☐☐☐☐☐

School Grade	Day-care	Pre-K3	Pre-K4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

6. How many **primary teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns?** ☐☐

7. How many **permanent teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns** ☐☐
   - **c. Extracted due to caries?** ☐☐

8. What type of dental insurance does the patient have? Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name ______________________________

Dental Provider Signature ______________________

Dental Examination Date ______________________

Dental Office Stamp

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

BELLAS ARTES CHILD CREATIVITY CENTER

Please add your child's picture.

Por favor agregar una foto de su niño.

My name is/Mi nombre es: ____________________

I was born on/ Yo naci el: ____________________

I am/ Yo tengo: ____________Months old/ meses de edad

I am/ Yo tengo: ____________ years old/ años de edad

I am allergic to/ Yo soy alérgico/a (a) ______________________________

Food preferences/ Alimentos preferidos______________________________

In case of emergency call to: ( ) ______________________________

En caso de emergencia llamar a: ( ) ______________________________

Additional telephone numbers and persons authorized to pick me up.
Números adicionales de teléfono y personas autorizadas para recogerme.

Parent's name #1____________________ Phone/Telephone ( ) ____________

Parent's name # 2____________________ Phone/Telephone ( ) ____________

Name / nombre____________________ Phone/Telephone ( ) ____________

Name / nombre____________________ Phone/Telephone ( ) ____________

Name / nombre____________________Phone/Telephone ( ) ____________

____________________	____________________	____________________
Parent's name/ Nombre del padre	Signature/ Firma	Date/ Fecha

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

○ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/ monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

○ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

____

Parent or guardian's signature

____

Date

Child's Name:______________________________________

Child's date of birth:_________________________________

If child was born 3 or more weeks prematurely, # of weeks premature:__________

Child's primary physician:_____________________________

Ages & Stages Questionnaires®, *Third Edition (ASQ-3™)*, Squires, Twombly, Bricker & Potter.
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www.agesandstages.com | 1-800-638-3775 |

BELLAS ARTES EXCLUSION POLICY

Control of communicable disease should be Parents & Teachers primary concern.

Policies and guidelines related to outbreaks of communicable diseases and illnesses in this facility have been developed with the help of the local health department and local pediatrician in order to protect the group as a whole as well as the health of your own child. I ask that parents assist me by keeping sick children at home. If they have or have experienced any of the following symptoms in the past 24 hours they need to be kept at home and away from this facility and bring a medical excuse that secure your child can return at the center

- A fever of 100* orally or 99* under the arm.
- Signs of a newly developed cough or a severe cough/unusual breathing, wheezing.
- Diarrhea, vomiting, or an upset stomach.
- Unusual or unexplained loss of appetite, fatigue, irritability, or headache.
- Any discharge or drainage form the eyes, nose, ears or open sores.
- Crying excessively, appears to be in pain, pulling on ears, discharge from ears.

Children who show signs or symptoms listed above will be returned home ASAP, (your child must be pick up in 1 hour) appreciate your cooperation with this policy. If you have any questions concerning this policy and whether your child should attend, please call me at 202-758-0395 before bringing your child to the childcare. I have read and understand this policy.

BELLAS ARTES POLIZA DE EXCLUSION

El control de las enfermedades transmisibles debe ser la preocupación principal de Padres y Maestros.

Las políticas y directrices relacionadas con brotes de enfermedades transmisibles y enfermedades en esta instalación se han desarrollado con la ayuda del Departamento de Salud y Pediatra local con el fin de proteger al grupo como un todo, así como la salud de su propio hijo. Pido que los padres me ayuden manteniendo a niños enfermos en casa. Si tienen o han experimentado alguno de los siguientes síntomas en las últimas 24 horas, deben mantenerse en casa y lejos de esta instalación y traer una excusa médica que asegure que su hijo pueda regresar al centro.

- Fiebre de 100 * oralmente o 99 * debajo del brazo.
- Signos de una tos recién desarrollada o tos severa / respiración inusual, sibilancias.
- Diarrea, vómito o malestar estomacal.
- Pérdida inusual o inexplicable de apetito, fatiga, irritabilidad o dolor de cabeza.
- Cualquier secreción o drenaje de los ojos, nariz, oídos o llagas abiertas.
- Llorar excesivamente si razón, parece tener dolor, jalándose los orejas, descarga de los oídos.

Los niños que muestren los signos o síntomas mencionados anteriormente serán devueltos a casa lo antes posible. (Su niño debe ser recogido en 1 hora) Agradezco su cooperación con esta política.
Si tiene preguntas sobre esta política y si su hijo debe asistir, por favor llámeme al 202-758-0395 antes de llevar a su hijo a la guardería. He leído y entiendo esta política.

____________________ ____________________

Parent's signature/ Firma del padre Date/ Fecha

____________________ ____________________

Provider signatura / firma del proveedor Date / Fecha