ENROLLMENT/RE-ENROLLMENT CHECKLIST

There are several registration forms to be completed prior to the beginning of the 24-25 school year. Below, please find a checklist to facilitate the completion of these forms. All forms are available on the school's website: www.stcoletta.org/school-program/.

Families of charter school students must also complete residency verification requirements!

FOR PARENT SIGNATURE

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

_____ **Community Outings Permissions** (CBI permission– all students; CBT permission– students ages 14 to 22)

_____ **Parent-School Compact** for 2024-2025

_____ **Photographic Release Form** (required for NEW students; Returning students- complete if you wish to change your student's current permission level)

_____ **Free and Reduced Lunch Form**

_____ **Parent Handbook/School Policies Receipt**

MEDICAL FORMS

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

_____ **Oral Health Care Certificate**

_____ **DC Child Health Certificate & Immunization Record**

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

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

St. Coletta of Greater Washington

Seeing possibilities beyond disabilities

ST. COLETTA OF GREATER WASHINGTON, INC.
EMERGENCY CARE INFORMATION
2024-2025

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

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

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

Is the above address a temporary address? ☐YES ☐NO

If yes, is this temporary living situation due to loss of housing or economic hardship? ☐ YES ☐ NO

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

Parent/Guardians' preferred language of communication:_____

Parent/Guardian 1 Name: _____
Last First
Address (if different than above): _____

Occupation/Employer: _____

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

Parent/Guardian 2 Name: _____
Last First
Address (if different than above): _____

Occupation/Employer: _____

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

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

1) _____
Name Relationship Phone Number(s)

2) _____
Name Relationship Phone Number(s)

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

_____
Signature of Parent/Guardian Date

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

ADDITIONAL INFORMATION

Student Name:_____

_____ _____

Name of Insurance Company **Name of Physician**

_____ _____

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

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

MEDICAL INFORMATION

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

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

_____

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

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

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

_____

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

_____

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

Student Name:_____

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

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

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

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PARTICIPATION IN COMMUNITY OUTINGS rev. 5/2023

Student name:_____

COMMUNITY BASED INSTRUCTION (ALL students)

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

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

When: During school hours

Please sign and date for permission for your child to participate in the community based instruction during the 2024-2025 school year. By signing below, you give St. Coletta permission to take the above student to the nearest hospital in the event you or an emergency contact cannot be reached in an emergency.

_____ _____

Parent signature date

CAREER-BASED TRAINING (14 years and older) rev. 6/2022

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

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

Please sign and date for permission for your child to participate in the Career-Based Training Program during the 2024-2025 school year.

_____ _____

Parent signature date

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Tel:(202) 350-8680 ■ Fax: (202) 350-8699
www.stcoletta.org

INSTRUCTIONS FOR APPLYING

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

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

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

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

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

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

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

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

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

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

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

Part 6: Answer this question, if you choose.

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

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

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

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

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

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

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

Part 6: Answer, this question if you choose.

FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

PART 1: ALL HOUSEHOLD MEMBERS

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

PART 2: BENEFITS

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

NAME: CASE NUMBER:

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

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

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

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

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

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

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

Sign here: Print name:

Date:

Address: phone number:

City: state: zip code:

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

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

Choose one ethnicity:

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Choose one or more (regardless of ethnicity)

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

☐ White ☐ Native Hawaiian or Other Pacific Islander

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

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

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

Household size:

Categorical Eligibility:

Eligibility: Free ☐ Reduced ☐ Denied ☐

Determining Official's Signature: date:

Confirming Official's Signature: date:

Verifying Official's Signature: date:

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

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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

St. Coletta of Greater Washington

Seeing possibilities beyond disabilities

VIDEO/PHOTOGRAPHIC PERMISSION

Student's Name: _____

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

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

Please indicate level of consent by selecting one option below:

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

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

_____ _____

Signature of Parent/Guardian Date

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

Rev: 4/2024

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Tel:(202) 350-8680 ■ Fax: (202) 350-8699
www.stcoletta.org

School-Parent/Guardian Compact (SCHOOL COPY)

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

This school-parent compact is in effect during the 2024-2025 school year.

School/Teacher Responsibilities

St. Coletta School will:

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

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

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

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

Parent/Guardian Responsibilities

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

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

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

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

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

_____	_____
Signature of School Representative/Teacher	**Date**
_____	_____
Signature of Parent/Guardian	**Date**

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

St. Coletta of Greater Washington

Seeing possibilities beyond disabilities

June 2024

Dear Parents/Guardians:

We are excited for another school year and would like to share a few updates regarding health requirements. Attached are forms for medical orders pertaining to medications, feeding tubes, and other medical procedures for school. In accordance with the DC School Health Program, all medical orders must be renewed by the physician at the beginning of each school year. **Please provide all orders and medications prior to our first day of school so that we are prepared to serve your child.** Medication, tube feedings, and nursing procedures cannot be administered without these properly completed permission forms. Please ensure that we have new medications if the current medications are expired.

D.C. Department of Health (DOH) has strict immunization requirements continuing in the upcoming school year. Please have your medical provider review your child's immunization record and provide updates as needed. These immunizations are **mandatory** for school attendance.

In addition, physical and dental examinations are required annually. The necessary forms are enclosed.

If you have any questions, please email the nursing office at jehan.jones@stcoletta.org. The office fax number is 202-350-8658.

Thank you,
St. Coletta Nursing Team

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

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DC School Immunization Requirements Guide

effective June 2023

This is a summary of vaccines required for children to enter key grades in the District of Columbia. **The number of ✓ is the total number of doses needed to enter those grades.** More detail on the requirements is available at **dchealth.dc.gov/immunizations.**

To start Pre-K3*	To start Kindergarten	To start 7th grade	To start 11th grade
DTaP ✓✓✓✓	DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓
Polio ✓✓✓	Polio ✓✓✓✓	Polio ✓✓✓✓	Polio ✓✓✓✓
Chickenpox ✓	Chickenpox ✓✓	Chickenpox ✓✓	Chickenpox ✓✓
MMR ✓	MMR ✓✓	MMR ✓✓	MMR ✓✓
Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓
Hepatitis A ✓✓	Hepatitis A ✓✓	Hepatitis A ✓✓	Hepatitis A ✓✓
Pneumococcal (PCV) ✓✓✓✓		Tdap ✓	Tdap ✓
Haemophilus Influenzae Type B (Hib) ✓✓✓(✓) *Depending on brand used*		HPV ✓✓	HPV ✓✓
		Meningococcal (ACWY) ✓	Meningococcal (ACWY) ✓✓

✓ = number of doses

***Your Pre-K3 child may become eligible for a booster dose of vaccines against MMR, Chickenpox, Polio, and Diptheria/Tetanus/Pertussis when they turn 4 years of age. We highly encourage getting these on time, however these will not count against the attendance requirement mid-year.**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Dear Parent/Guardian,

In 2009, the District of Columbia passed a law, DC Law 17-10 Human Papillomavirus Vaccinations and Reporting Act of 2007 that requires students enrolling in grades 6 through 12 for the first time at a school in the District of Columbia to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or

2. Not received the HPV vaccine this school year because:

    a. The parent or guardian has objected in good faith and in writing to the chief of the school that the vaccination would violate his or her religious faith;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or guardian, at his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Each year, health care providers diagnose more than 32,000 new cases of cancer related to HPV. The HPV vaccine can help protect your child from nine HPV-associated cancers including cervical cancer in women, and cancers found in the mouth and throat in men and women. As parents/guardians, you make many decisions to keep your children free from disease. Being informed about HPV is an important decision. The HPV vaccine is safe and can help protect your child from cancer; it works best when it is given to a child prior to exposure to the virus. The vaccine can be given at the same time as other recommended vaccines and is administered in a two- or three-dose series, depending on your child's age when the vaccine series is started. It is important to complete the series.

Please review the information provided on the reverse side of this letter. After reading the information, as a parent/guardian, you may choose to have your child vaccinated or to Opt-out of the HPV vaccine school requirement. However, DC Health strongly proposes that children be vaccinated as recommended by the Centers for Disease Control and Prevention (CDC).

Contact your health care provider to determine when your child can receive the vaccine series. Take this opportunity to discuss HPV and other vaccines with the provider.

If you require additional information, contact the DC Health Immunization Program at (202) 576-7130.

HUMAN PAPILLOMAVIRUS

What is human papillomavirus (HPV)?

Human Papillomavirus (HPV) is a common family of viruses that causes infection of the skin or mucous membranes of various parts of the body. There are over 100 different types of HPV viruses. Different types of HPV infections affect different areas of the body. For instance, some types can lead to abnormal cells on the cervix, vulva, anus, penis, mouth, and throat, sometimes leading to cancer.

What are the symptoms?

Most people with HPV do not develop symptoms or health problems. In 90% of cases, the body's immune system clears HPV naturally within two years.

How common is HPV?

HPV is very common. It will infect most people at some point in their lives. Most infected people do not know it. Most HPV infections go away on their own without lasting health problems. However, there is no way to know which infections will turn into cancer or other health problems.

How is HPV spread?

Exposure to HPV can happen with any kind of adolescent experimentation that involves genital contact with someone who has HPV - intercourse isn't necessary, but it is the most common way to get the virus. Because HPV often has no visible signs or symptoms, anyone can get the virus or pass the virus on without knowing it.

Is there treatment for HPV?

Once a person is infected, there is no treatment for HPV infections, but there are treatments for the HPV-related diseases such as genital warts and certain cancers that may develop. Most infections will clear on their own, but there is no way to know who will develop cancer or other health problems. **Prevention is better than treatment.**

How can HPV be prevented?

The best way to prevent HPV infection is to get vaccinated with the HPV vaccine. The vaccine can prevent the HPV types that cause cervical cancer in women and genital warts and certain other cancers in both males and females.

Is the HPV vaccine safe?

HPV vaccine has been shown to be very safe. Every vaccine used in the United States is required to go through rigorous safety testing before licensure by the Food and Drug Administration (FDA). People who have had a life-threatening allergic reaction to yeast, or are pregnant, have a moderate to severe illness should not receive the vaccine. Side effects are generally mild and may include a sore arm, fever, and redness and tenderness at the injection site.

Who should get the HPV vaccine?

Doctors recommend that boys and girls get HPV vaccine at age 11 or 12 for the best protection from HPV cancers. The vaccine can be given as early as age 9. The vaccine is given in two shots if started before age 15 years, with 6 to 12 months between shots. Teens who start the series later or have a weak immune system will need 3 shots.

Vaccination is not a substitute for cervical cancer screening. This vaccine does not protect against all HPV types that can cause cervical cancer. Women should still get regular Pap tests.

How can I protect my child from HPV disease?

Don't wait to vaccinate. Talk to your health-care provider today about protecting your son or daughter from HPV infection.

Where can I get more information?

- Your health care provider
- DC Health Immunization Program at (202) 576-7130
- Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636) or http://www.cdc.gov/hpv

Sources

American College of Obstetrics and Gynecologists (ACOG) Committee on Adolescent Health Care, Fact Sheet: Human Papillomavirus. ■ www.acog.org

CDC Vaccine Safety Information for Parents. ■www.cdc.gov/vaccinesafety/populations/parents.html

CDC. National Center for Immunizations and Respiratory Diseases. HPV Vaccine-Questions and Answers. ■ www.cdc.gov/hpv/parents/questions-answers.html

Immunization Action Coalition's vaccine information website: ■ www.vaccineinformation.org

DC HEALTH
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MURIEL BOWSER, MAYOR

Annual Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

Instructions for completing HPV Vaccination Opt-Out Certificate (Return Completed Certificate to school, keep copy of information sheet for your reference)

Section 1: Before signing, read the information sheet on HPV and the HPV Vaccine.

Section 2: Parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 2 Student Information

School Name:

Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Health Care Provider:	City:	Zip Code:	Phone:

My child's health care provider recommended the HPV vaccine. Yes ☐ No ☐

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After reviewing the information about the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may revisit this decision at any time during the recommended vaccination window and complete the required vaccinations.

_____ _____

Signature of Parent/Guardian or Student if 18 years or older Date

_____

Print Name of Parent/Guardian or Student if 18 years or older

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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)

	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 Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

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.

DC HEALTH
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Universal Health Certificate

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

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

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

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

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

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

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

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

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

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

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

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

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

What is the child's risk level for TB?

- ❑ High ➔ *complete skin test and/or Quantiferon test*
- ❑ Low

Skin Test Date:			**Quantiferon Test Date:**	
Skin Test Results:	❑ Negative	❑ Positive, CXR Negative	❑ Positive, CXR Positive	❑ Positive, Treated
Quantiferon Results:	❑ Negative	❑ Positive	❑ Positive, Treated	

Additional notes on TB test:

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

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

HGB/HCT Test Date:	**HGB/HCT Result:**

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

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

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

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

Medical Exemption (if applicable)

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

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV
☐ COVID-19

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

Reason for the medical exemption:_____

Alternative Proof of Immunity (if applicable)

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

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

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

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

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

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

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

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

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

DC | HEALTH

Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

Student First Name:	**Student Last Name:**	**Grade:**
School Facility Name:		**Student DOB:**
Parent First Name:	**Parent Last Name:**	
Parent Email:		**Parent Phone:**

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	**End date for school administration of this medication:**

This medication is: ❑ New; the first dose was given at home on date and time: _____ ❑ Renewal ❑ Change

Is this a standing order?
- ❑ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
- ❑ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
- ❑ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
- ❑ Yes, other: _____
- ❑ No

Name and strength of medication:	**Dose/route:**

Time and Frequency at School *(e.g. 10am and 2pm every day; as needed if standing order)*

If a reaction can be expected, please describe:

Additional instructions or emergency procedures:

Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

Diagnosis:	**This procedure is:** ❑ New ❑ Renewal ❑ Change

Treatment:

When should treatment be administered at school? *(e.g. 10am and 2pm every day)*

End date for school administration of this treatment:

Additional instructions or emergency procedures:

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ❑ Yes ❑ No

Licensed Health Care Provider Office Stamp

Provider Name:	
Provider Phone:	
Provider Signature:	**Date:**

OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

Name:	**Signature:**	**Date:**