DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Year 2019/2020 Enrollment Packet

Welcome to the 2019/2020 school year with DC Public Schools! Please complete this enrollment packet for the upcoming school year 2019-2020. We've made each of the forms available as fillable PDFs so you can type your answers and have information pre-populate throughout the packet.

When you're done, simply print the packet, gather your supporting documents, and take them to your school's front office. Step by step instructions are included below. You can locate all documents online at http://enrolldcps.dc.gov/. Translations are available in Amharic, Chinese, French, Spanish, and Vietnamese. At DCPS, we do not share student information with the federal government.

At DCPS it is our mission to ensure that each of our schools provides a world-class education that prepares ALL of our students, regardless of background or circumstance, for success in college, career, and life. It is an honor and a privilege to serve all students, and we look forward to another wonderful school year.

Step 1. Complete the forms in this packet.

A. Enrollment Form
B. Residency Form
C. Consent Forms (Media Consent and Release, Release of Information to Military Recruiters, and Social Emotional Health Services)
D. My School DC Seat Acceptance *(if applicable)*
E. Notifications of Student and Parent/Guardian Rights
F. Dietary Accomodation Form *(if applicable)*
G. Immunization Requirements
H. Universal Health Form
I. Oral Health Form
J. Medication Plan/Procedure Form *(if applicable)*

Step 2. Gather your supporting documents.

A few supporting documents are required to enroll your student:

New to any DCPS school

A. One proof of age – examples include a birth certificate, hospital records, previous school records, passport, or baptismal certificate
B. Proof of residency – *see Residency Form for a complete list of acceptable documents and verification methods*

Returning to your current DCPS school

- Proof of residency – *see Residency Form for a complete list of acceptable documents and verification methods*

Step 3. Submit all the packet and support documents to your student's school office.

Enrollment packets should be brought to your student's 2019/2020 school typically during business hours.

Step 4. Mark your calendar to complete the Free Lunch Application.

The application for households to receive free lunch will be available July 2019. Applications will be emailed to families. All families are encouraged to submit an application.

Please note DCPS is required by law to annually verify the District residency of each family seeking to enroll in DCPS. DCPS conducts this residency verification upon enrollment (residency must be verified within **ten calendar days** from the date the student first seeks to enroll). If you are unable to verify District residency in accordance with District requirements or you fail to agree to pay non-resident tuition, your student will be at risk for exclusion from attending DCPS. For any questions, please contact the DCPS Enrollment Team at enroll@k12.dc.gov or 202-478-5738.

***Notice of Non-Discrimination**: In accordance with state and federal laws, the District of Columbia Public Schools does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business. For the full text and additional information, visit http://dcps.dc.gov/non-discrimination.*

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

School Year 2019/2020 Enrollment Form

Use this form to enroll each of your new or returning students in a DC public school. Submit this form in-person at the school your student will attend for the 2019/2020 school year. All questions below must be answered.

DCPS Student

First Name:	**Last Name:**	**Date of Birth:**
Country of Birth:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:** **City:**	**State:** **ZIP:**
School Year 2018/2019 **School Name:**	**City:**	**State:**
School Year 2019/2020 **School Name:**		

Grade Level for School Year 2019/2020: *check only one*

☐ Pre-K3 ☐ Pre-K4 ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ Adult Education

Migrant Status: In the past 36 months, has the student, their child, spouse, parent or guardian engaged in migrant work (meaning they moved and worked seasonally in jobs related to agriculture or fishery)? ☐ No ☐ Yes

Housing Status: *check only one*

☐ Permanent (own, rent) ☐ Hotel/Motel ☐ Shelter ☐ Doubled Up
☐ Unaccompanied Youth ☐ Foster Care/CFSA ☐ Awaiting Foster Care ☐ Unsheltered

Ethnic Designation: *check only one* ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: *check all that apply* ☐ American Indian/Alaska Native ☐ Asian ☐ Ntv Hawaiian/ Pac Isldr ☐ Black/African Am. ☐ White

Does student have the following? *Check all that apply. School may follow up.* ☐ 504 plan ☐ Required medication ☐ IEP for special education services ☐ Dietary restrictions ☐ Allergies

Parent/Guardian/Custodian/Caregiver

Caregiver One

First Name:	**Last Name:**	**Relationship to Student:**		
Email:	**Phone:** ☐ Cell ☐ Landline			
☐ Same as student **Address:**	**Apt:**	**City:**	**State:**	**ZIP:**
☐ I do NOT want to receive required communications about my student by emails/texts.				

Caregiver Two

First Name:	**Last Name:**	**Relationship to Student:**		
Email:	**Phone:** ☐ Cell ☐ Landline			
☐ Same as student **Address:**	**Apt:**	**City:**	**State:**	**ZIP:**
☐ I do NOT want to receive required communications about my student by emails/texts.				

Home Language Survey

If answers to the following questions indicate that a language other than, or in addition to, English is spoken in the home, the student's English proficiency will be evaluated to ensure that services are offered to students who need them. For questions, please call the Language Acquisition Division at 202-671-0750.

Is a language other than English spoken in your home? ☐ No ☐ Yes, _____ *(specify language)*

Does your child communicate in a language other than English at home? ☐ No ☐ Yes, _____ *(specify language)*

In what language would you like to receive information from the school? *If "other" is selected, written correspondence will be sent in English. Interpretation will be provided when available.*

☐ English ☐ Spanish ☐ Amharic ☐ French
☐ Chinese ☐ Vietnamese ☐ Other: _____

Emergency Contacts

If the two adults listed above cannot be reached, who has permission to pick up the student?

Full Name:	**Relationship to Student:**	**Phone:**
Full Name:	**Relationship to Student:**	**Phone:**

Student's Siblings in DCPS

Please provide information for all of the student's siblings who attend any DCPS school.

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Full Name:				
Date of Birth:				

Certification of Person Enrolling Student

I confirm all the information provided above is correct to the best of my knowledge. I understand that DCPS will keep this information confidential and will use it for DCPS business only. I understand that providing false information is punishable by law.

Print Name: _____ **Signature**: _____ **Date**: _____

DC Residency Verification Form

Use this form to verify that you are a District resident and therefore you or your student is eligible to enroll in a DC public or public charter school.

Step One: Choose the residency verification method that best applies to you.

Details of all the available methods for verifying your DC residency are provided on page two. **Choose ONE** after completing sections 2 and 3 below. To be eligible to enroll in in a DC public or public charter school: 1) the person enrolling the child must be the parent or the valid legal guardian, custodian or Other Primary Caregiver with proper documentation; 2) the person has established a physical presence in the District of Columbia; and 3) the person has submitted valid and proper documentation that establishes residency as set forth in law and regulations.

Step Two: Provide information about your family.

Student First Name:	**Student Last Name:**	**DOB:**
Name of SY18/19 School:	**Name of SY19/20 School:**	
Person enrolling the student > First Name:	**Last Name:**	

I am the:
- ☐ adult student and completed the sworn statement
- ☐ minor student and completed the sworn statement
- ☐ student's parent/guardian/custodian
- ☐ student's other primary caregiver and completed the OPC Form

Address of person enrolling the student:	**City:**	**State:**	**ZIP:**
Email:	**Phone:**		

Step Three: Certification of Residency Requirements

- I certify that I am the parent or the valid guardian, custodian, or other primary caregiver and am submitting valid and proper documentation accordingly;
- I certify that I have established and will maintain a physical presence in the District, defined as the "actual occupation and inhabitance of a place of abode with the intent to dwell for a continuous period of time"; and I am submitting valid and proper documentation to verify residency, as set forth in 5-A DCMR § 5004.
- I understand that enrollment of the above-named student in District of Columbia public schools, public charter schools, or other schools providing educational services funded by the District of Columbia is based on my representation of **bona-fide DC residency, including this sworn statement of physical presence and my submission of valid and proper documentation verifying residency**.
- I understand that even if the documentation I provide appears to be satisfactory, OSSE or school officials, with reasonable basis, may seek further information to verify the student's residency or the other primary caregiver status of the adult enrolling the student.
- If the District of Columbia, through the Office of the State Superintendent of Education, determines that I am not a resident, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school.
- I understand that if I provide false information or documentation, I can be referred to DC Office of the Inspector General for criminal prosecution or to the DC Office of the Attorney General for prosecution under the False Claims Act and under D.C. Code § 38-312 which provides that any person who knowingly supplies false information to a public official in connection with student residency verification shall be subject to payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both a fine and imprisonment.
- I understand that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies including but not limited to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request.
- I am aware that the District of Columbia may use whatever legal means it has at its disposal to verify my residence, and may share with appropriate local authorities for verification and/or investigation.
- **I agree to notify the school of any change of residence for myself or the student within three (3) school days of such change**.

Signature of Person Enrolling Student: _____ **Date**: _____

Step Four: Bring this completed form and applicable documentation to your school.

SCHOOL OFFICIAL USE ONLY The following method was used and/or presented as proof of District of Columbia residency. Choose ONE.

I certify, under the penalties of perjury, that I have personally reviewed all the documents presented and affirm that the information represented above is true to the best of my knowledge, information, and belief. I also affirm that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies, including but not limited, to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request.

School Official Name (print): _____ **Signature**:_____ **Date**: _____

- ☐ **Method A: School official verified**
  - ☐ DC financial assistance verification
  - ☐ Homeless liaison has provided homeless verification
  - ☐ Ward of DC
- ☐ **Method B:** Office of Tax Revenue
- ☐ **Method C: One document**
  - ☐ Pay stub
  - ☐ DC Gov financial assistance
  - ☐ Embassy letter
  - ☐ DC Tax Form-D40
  - ☐ Military housing orders
- ☐ **Method C: Two documents**
  - ☐ DC motor vehicle registration
  - ☐ DC driver's license/non-driver ID
  - ☐ Lease with payment
  - ☐ Utility bill with payment
- ☐ **Method D:** Home visit

Parents/Guardians, follow ONE of the methods (A-D) to verify your DC residency.

Method A

Verify with a school official.
If you are homeless, a ward of the District, and/or a participant of a District public benefits program, such as Medicaid, Supplementation Nutrition Assistance Program, or Temporary Assistance for Needy Families – your school may already have your information. Check with your school official or the school's homeless liaison.

Method B

Verify through the Office of Tax and Revenue's website.
Re-enrolling families/students are often able to verify residency using OTR residency verification process. The person enrolling the student or the adult student must have paid taxes in DC during the previous fiscal year and have the student's social security number. Login to the system at ossedctax.com. Your information will then be sent directly to your school.

Method C

Verify by submitting supporting documentation.
Provide hard copies. The address and name on each of the items must be the same as on the completed form.

ONE item is needed from this list to verify residency.

- A valid **pay stub** issued within forty-five (45) days of providing proof of residency. Must contain the name of person enrolling the student or the name of the adult student showing his/her current DC home address, and withholding of only DC personal income tax for the current tax year and no other states listed.
- **Unexpired official documentation of financial assistance from the Government of the District of Columbia,** issued to the person enrolling the student or the adult student and current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs.
- **Certified copy of Form D40** by the DC Office of Tax and Revenue, with the name of person enrolling the student or the name of the adult student as evidence of payment of DC taxes for the current or most recent tax year.
- **Current military housing orders or statement on military letterhead, both of which shall include** the name of the person enrolling the student or the name of the adult student, and the residing District address.
- **Embassy letter** issued within the past twelve (12) months. Must contain the name of the person enrolling the student or the adult student and an official embassy seal. Must indicate that the caregiver and the dependent student or the adult student currently live on embassy property in DC or will reside on DC property during the relevant school year.

OR

TWO items are needed from this list to verify residency.

- Valid and unexpired **DC motor vehicle registration** showing the name of the person enrolling the student or the name of the adult student and his/her current District home address.
- Valid and unexpired **lease or rental agreement with a separate proof of payment of rent**, in the name of the person enrolling the student or the name of the adult student, for a period within two (2) months immediately preceding of the submission of this form, for the current DC address at which the person enrolling the student actually resides.
- Valid and unexpired **DC motor vehicle operator's permit** or official government issued non-driver identification in the name of the person enrolling the student or the name of the adult student showing his/her current DC home address.
- **Utility bill** (***only gas, electric, and water bills are acceptable***) **with a separate paid receipt showing payment of the bill**, from a period within the two (2) months immediately preceding the submission of this form, listing the name of the person enrolling the student or the name of the adult student and his/her current DC home address.

Method D

Verify through an alternative method.
If you are unable to verify through one of the above methods, speak with your school official about a home visit.

DISTRICT OF COLUMBIA
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School Year 2019/2020 Consents

Use this form to tell DC Public Schools your preferences on 1) sharing your student's information in the media; 2) providing social emotional services to your student; and 3) releasing your student's information to military recruiters.

DCPS Student.

First Name:	**Last Name:**

OPTIONAL – Media Consent and Release

By signing below, I hereby grant the District of Columbia, including DCPS, and its employees and agents, successors, and assignees the right to: (1) record my student's image and voice; (2) edit such recordings at their discretion; and (3) use such recordings, along with the artwork and written work of my student on videotape, in photographs, in digital media, and in any other form of electronic or print media. I understand that this release does not grant DCPS or the District of Columbia the right to disclose any biographical or other identifying information regarding my student and that I may revoke this consent at any time by contacting my school.

I hereby release DCPS and the District of Columbia, their successors, and their assignees and anyone using my child's image and/or voice, artwork, and/or written work pursuant to this release from any and all claims, damages, liabilities, costs and expenses which I or my child now have or may hereafter have by reason of any use thereof.

I understand that the provisions of this release are legally binding. This consent is valid through the end of the school year and can be revoked at any time.

☐ I consent. ☐ I do not consent.

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

OPTIONAL – Release of Information to Military Recruiters (6th through 12th Grade)

Federal laws require that DCPS provides military recruiters, upon request, with the name, address, and telephone number ("information") of all 6th through 12th grade students unless the parent/legal guardian of a student (or the student if an adult) has opted out of such disclosure by signing below. This consent is valid through your student's time enrolled at a DCPS and can be revoked at any time.

☐ I request that DCPS not release my student's/my (if student is an adult) information to military recruiters.

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

OPTIONAL – Social Emotional Health Services

DCPS has highly qualified professionals to help students experiencing stress, sadness, anger, or other emotions that can impact their lives. DCPS will adhere to all confidentiality guidelines to protect the privacy of your student. By signing below, you authorize DCPS school professionals to begin the process of working with your student. You will be notified and included in any plan for services, consistent with best practices. Your student's information will be reviewed by the School Mental Health Team and will be handled confidentially. This consent is valid through the end of the school year and can be revoked at any time.

If you consent, please check which of the following your student has or is experiencing:

☐ Parental divorce/separation ☐ Homelessness ☐ Foster care
☐ Incarcerated parent ☐ Death of close family ☐ Other trauma: _____

Would you like to be contacted by a member of the School Mental Health team to discuss further? ☐ Yes ☐ No

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

MY SCHOOL DC
The Public School Lottery
MySchoolDC.org

SEAT ACCEPTANCE FORM
2019-20 School Year

Parents/Guardians: If you participated in the My School DC lottery, please complete this form to confirm your child accepts a seat in a My School DC school and submit it with other enrollment requirements to the school in person.

Student Information

You must fill out one form for each child you are enrolling that participated in the My School DC lottery.

First and Last Name:	**Date of Birth (MM/DD/YYYY):**
Current School (2018-19):	**Current Grade (2018-19):**
Enrolling School (2019-20):	**Enrolling Grade (2019-20):**

Records Release

Please read and sign the bottom of this form so that the enrolling school can request your child's records.

By signing this form, I authorize the enrolling school to request records from the current school for the student above. I also hereby authorize the enrolling school to request records from any other previous schools that the student above has attended. I understand that the enrolling school will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation

Please read and sign the bottom of this form to confirm your understanding of each statement and your child's enrollment for 2019-20.

I understand that I cannot maintain enrollment at more than one school for 2019-20 and I am confirming my enrollment at the "Enrolling School" above.

I understand that once this form is submitted, I will give up my space at my current school for next school year (2019-20) and my current school will be notified that my space may be awarded to another family.

I understand that if I enroll as a result of receiving a waitlist offer from this school that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Parent/Guardian Information

This should be the same person completing the form.

Signature: _____ **Print Name:** _____ **Date:** _____

FOR OFFICE USE ONLY **Application Tracking #:** _____

DISTRICT OF COLUMBIA
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School Year 2019/2020 Notifications

This document outlines the rights of parents/guardians and their DCPS student.

Every Student Succeeds Act of 2015

This notice is to inform you that you have the right to request information regarding the professional qualifications of your student's classroom teachers under the Every Student Succeeds Act of 2015, At any time, you may ask for the following information:

- Whether a teacher has met District of Columbia qualification and licensing criteria for the grade levels and subject areas in which the teacher provides instruction;
- Whether a teacher is teaching under an emergency or other provisional status through which District of Columbia qualification or licensing criteria have been waived;
- Whether a teacher is teaching in the field of discipline of the teacher's certification;
- Whether a student is being provided services by paraprofessionals (non-certified instructional aides that assist in the classroom under teacher supervision) and, if so, the qualifications of the paraprofessionals.

Please submit all requests and any other questions you may have related to this notice to DC Public Schools by email to dcps.hrdataandcompliance@dc.gov or by fax to (202) 535-2483.

Protection of Pupil Rights Amendment

This notice informs parents/guardians and eligible students (emancipated minors or students 18 and older) of their rights regarding the administration of surveys and physical examinations/screenings and the collection and use of personal information for marketing purposes. These rights are stated in the Protection of Pupil Rights Amendment (20 U.S.C. § 1232h; 34 CFR Part 98) ("PPRA") and are provided in this document as well. DCPS has developed and adopted policies regarding these rights, as well as procedures to protect student privacy in the administration of surveys and the collection, disclosure, and use of personal information for marketing, sales, or other distribution purposes. The DCPS Survey Calendar, available at https://dcps.dc.gov/surveys, notifies parents/guardians and eligible students, at the beginning of each school year and on a continuing basis, of the specific or approximate dates of protected information surveys and physical examinations/screenings administered to students. For all physical examinations/screenings and all surveys requiring passive consent, DCPS provides parents and eligible students with forms indicating they wish to opt a student out of participating in the activity. As a parent/guardian of a student or as an eligible student, you have the following rights under the PPRA:

1. **Consent to surveys**. Parents/Guardians and eligible students must consent before students are required to submit to a survey that is funded in whole or in part by a program of the U.S. Department of Education (USDE) and concerns one or more of the following categories of protected information:
    - Political affiliations or beliefs of the student or student's parent;
    - Mental or psychological problems of the student or student's family;
    - Sexual behavior or attitudes;
    - Illegal, antisocial, self-incriminating, or demeaning behavior;
    - Critical appraisals of others with whom respondents have close family relationships;
    - Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
    - Religious practices, affiliations, or beliefs of the student or parents; and
    - Income, other than as required by law to determine program eligibility.
2. **Ability to opt out**. Parents/Guardians and eligible students will always have an opportunity to opt a student out of the following:
    - Any survey of protected information not funded by the USDE;
    - Any nonemergency, invasive physical exam or screening required as a condition of attendance administered by the school or its agent and not necessary to protect the immediate health and safety of a student (except hearing, vision, and scoliosis screenings and any physical exam/screening required under state law); and
    - Any activities involving collection, disclosure, or use of personal information collected from students for marketing, sale, or distribution (this does not apply to the collection, disclosure, or use of personal information collected from students for the *exclusive* purpose of developing, evaluating, or providing educational products or services for, or to, students or educational institutions).
3. **Right to inspect**. Parents/Guardians and eligible students, upon request and before their administration or usage, may inspect:
    - Surveys of protected information of students and surveys created by third parties;
    - Instruments used to collect personal information for any marketing, sales, or other distribution purposes; and
    - Instructional material used as part of the educational curriculum.

Parents/guardians and eligible students who believe their rights have been violated may file a complaint at the following address: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, S.W., Washington, D.C. 20202.

The Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) affords parents/guardians and students aged 18 or older ("eligible students") certain rights with respect to a student's education records. This document is meant to notify you of specific important rights you have:

1. **The right to inspect and review the student's education records** within 45 days of the day the District of Columbia Public Schools (DCPS) receives a request for access. Parents/Guardians or eligible students should submit to the school principal a written request that identifies the record(s) they wish to inspect. The school principal or other appropriate school official will make arrangements for access and notify the parent/guardian or eligible student of the time and place where the records may be inspected.

2. **The right to request amendment of the student's education records** that the parent/guardian or eligible student believes are inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA. Parents/Guardians or eligible students may write the school principal, clearly identify the part of the record they want changed, and specify why it should be changed. If DCPS decides not to amend the record as requested by the parent/guardian or eligible student, the school will notify the parent/guardian or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent/guardian or eligible student when notified of the right to a hearing.

3. **The right to consent (in writing) to disclosures of personally identifiable information** contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. For example, DCPS discloses education records without consent to officials of another school or school district in which a student seeks or intends to enroll, or is already enrolled, when such disclosure is requested for purposes of the student's enrollment or transfer. In addition, FERPA authorizes disclosure without consent to school officials whom DCPS has determined to have legitimate educational interests. A school official is a person employed by DCPS as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person or company with whom DCPS has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); or a parent/guardian, student or other volunteer serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

4. **The right to file a complaint** with the U.S. Department of Education concerning alleged failures by DCPS to comply with the requirements of FERPA. The name and address of the office that administers FERPA are: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Ave. SW, Washington, DC 20202.

5. **The right to withhold disclosure of directory information**. At its discretion, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without the consent of parents/guardians or eligible students in accordance with the provisions of District law and FERPA. Parents/Guardians or eligible students may instruct DCPS to withhold any or all of the information identified above by completing the Release of Student Directory Information section below.

OPTIONAL – Do Not Release Student Directory Information

You may elect to restrict the information DCPS releases. Please mark the items below that you do *not* want DCPS to disclose without your consent, if any:

- ❑ Student Name
- ❑ Student Address
- ❑ Parent/Guardian Email
- ❑ Grade Level
- ❑ Participation in Officially Recognized Activities and Sports
- ❑ Weight and Height of Members of Athletic Teams
- ❑ Names of Schools Previously Attended
- ❑ Student's Date and Place of Birth
- ❑ Diplomas/Awards Received
- ❑ Dates of Attendance
- ❑ Student Telephone Listing
- ❑ Name of School Attending

By signing below, I affirm that:

- DCPS shall not disclose any information item I have placed a checked above;
- I hereby consent that DCPS may disclose any information item that I have not checked; and
- However, I understand that DCPS may still disclose this information if it is required to do so or if it is permissible under FERPA.

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

DC HEALTH Immunization Requirements for School Year 2019-2020

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

On the first day of school my student is:	By the start of SY19-20, my student should have received:[i]
2-3 years old	4 doses of Diphtheria/Tetanus/Pertussis (DTaP) 3 doses of Polio 1 dose of Varicella if no history of chickenpox [ii] 1 dose of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
4 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses Hepatitis B 2 doses Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
5-10 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A
11+ years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP)/Td 1 dose of Tdap 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A[iii] 1 dose of Meningococcal (Men ACWY)[iv] 2 or 3 doses of Human Papillomavirus Vaccine (HPV)[v]

[i] The number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's health suite personnel or health care provider for details.

[ii] All Varicella/chickenpox histories MUST be verified by a health care provider and documented with month and year of disease.

[iii] If born on or after 01/01/05.

[iv] Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

[v] Two doses if student receives first dose between ages 9 -14 (doses 6-12 months apart); 3 doses if student starts series on or after age 15.

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

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 First Name:	**Parent Last Name:**	**Parent 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
- ☐ Development
- ☐ 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 test by the age of 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal	**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.

Immunizations	Provide in the boxes below 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):				
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				

☐ 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

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 child care activities except as noted on page one. ☐ No ☐ Yes

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

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:

Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

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
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/child care facility.

Instructions

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

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

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

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

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

	Yes	No
Q1 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).	☐	☐
Q2 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.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many of **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many of **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 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 child care 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

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:**

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

SY19/20 Dietary Accomodation Request Form

Use this form to alert DC Public Schools of the dietary accommodations your student needs for the school year. This form is not intended to accommodate student taste preferences. **Please provide this form to your student's school nurse**. You will be contacted by the food service dietitian via email when your request is fulfilled.

A. Student Information.

First Name:	**Last Name:**	**Date of Birth:**
School Year 2019/2020 School Name:		**Student ID:**

Grade Level for School Year 2019/2020: *(check only one)*

☐ Pre-K3 ☐ Pre-K4 ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ Adult Education

B. Student's Dietary Accommodations. *Check all that apply.*

☐ **A. Milk Substitution**: The student is requesting a milk substitute due to a medical or other special dietary need. DCPS has the discretion to select a specific brand of milk substitute, provided it meets specified USDA nutrient requirements. Juice cannot be offered as a milk substitute. DCPS cafeterias serve only nut-free items, so nut milks are not available.

☐ **B. Philosophical Accommodation:** The student is requesting dietary accommodations for philosophical reasons, such as following a plant based diet. **Dietary instructions, including list of foods to be omitted:** _____

_____

☐ **C. Food Intolerance/Medical Accommodation:** The student is requesting a dietary accommodation due to food intolerance(s) or other medical reasons. Please be advised that all DCPS cafeterias serve only nut-free items. ***A medical practitioner must complete the section below.***

Completed by Medical Practitioner for Option C

What is the student's medical condition and why does it restrict their diet? *(e.g. Type 1 Diabetes; allergy to wheat or fish.)*

_____

_____

_____

Food texture required: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Is the food allergy airborne? ☐ Yes ☐ No

Foods to omit:	Suggested Substitutions:

Medical Office Stamp

Medical Practitioner Name: _____

Medical Practitioner Signature: _____

Date: _____ **Medical Practitioner ID:** _____

C. Parent/Caretaker Signature

I confirm all the information provided above is correct to the best of my knowledge. I understand that the information on this form will remain in effect until the end of the school year for which it is received. When necessary throughout the school year, I will update this form to reflect changes in my student's medical and/or nutritional needs. I understand that DCPS may have discretion as to whether it is able to accommodate these requests.

Printed Name: _____ **Signature:** _____ **Date:** _____

Phone: _____ **Email:** _____