INGENUITYPREP

NEW STUDENT ENROLLMENT PACKET

Congratulations! Your child has earned a spot at Ingenuity Prep!

The following steps are required to complete his/her enrollment:

- ☐ Complete IP Re-Enrollment Forms
  (Online only — See page 2 of this packet)
- ☐ Submit health documents and birth certificate
  (Online or in-person — See pages 3-6)
- ☐ Complete DC Residency Verification
  (In-person only — See page 7)
- ☐ Attend a New Parent Meeting in April
  (In-person only)

↓

- ☐ Sign My School DC Confirmation of Enrollment
  (In-person only)

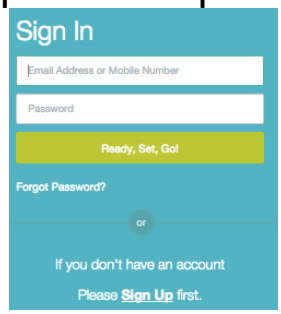
↓

Your child is officially enrolled for the 2017-18 school year at Ingenuity Prep!

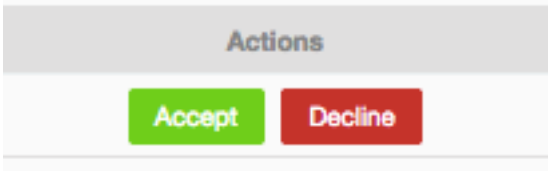
Deadline: May 1, 2017

Enrollment Form

1: Go to ingenuityprep.schoolmint.com and sign in with the username and password provided



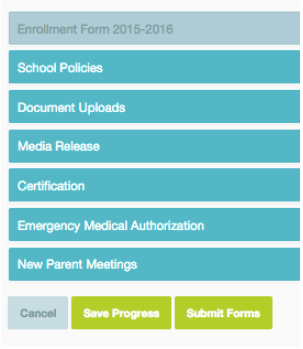
2: Accept your student's seat



3: Click Register to access forms

4: Complete forms

You may "Save Progress" at any time after completing your profile.



Deadline: May 1, 2017

District of Columbia Immunization Requirements[1]
School Year 2016 – 2017

All students attending school in the District of Columbia must present proof of appropriately spaced immunizations by the first day of school.

A Child 2 years or older entering Preschool or Head Start

- **4** Diphtheria/Tetanus/Pertussis (DTaP)
- **3** Polio
- **1** Varicella (chickenpox) – if no history of disease[2]
- **1** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 4 years old entering Pre-Kindergarten

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A
- **3** or **4** Hib (Haemophilus Influenza Type B)[3]
- **4** PCV (Pneumococcal)

A student 5 – 10 years old entering Kindergarten thru Fifth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP)
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **2** Hepatitis A (if born on or after 01/01/05)

A student 11 years & older entering Sixth thru Twelfth Grade

- **5** Diphtheria/Tetanus/Pertussis (DTaP/Td)
- **1** Tdap
- **4** Polio
- **2** Varicella (chickenpox) – if no history of disease[2]
- **2** Measles, Mumps & Rubella (MMR)
- **3** Hepatitis B
- **1** Meningococcal
- **3** Human Papillomavirus Vaccine (HPV)

[1] At all ages and grades, the number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's school nurse or health care provider for details.

[2] All Varicella/chickenpox disease histories MUST be verified/diagnosed by a health care provider (MD, NP, PA, RN) and documentation MUST include the month and year of disease.

[3] The number of doses is determined by brand used.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.*

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

Part 2: Child's Health History, Examination & Recommendations

Health Practitioner: Form must be fully completed.

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for children under age 6)*	Vision Screening Right 20/____ Left 20/____	☐ Glasses ☐ Referred ☐ Attempted	Hearing Screening Pass_____ Fail_____	☐ Device ☐ Referred ☐ Attempted

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

ANNUAL DENTIST VISIT: Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred ☐ **Fluoride Varnish** Date:_____

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

_____

_____

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

_____

_____

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

_____

_____

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

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ **POSITIVE**	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Practitioner:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: **202-698-4040**
LEAD EXPOSURE RISKS	**LEAD TEST DATE:**		RESULT:	**Health Practitioner:** *ALL* lead levels must be reported to DC Childhood Lead and Healthy Housing Program: Fax: **202-535-2607**	

Part 4: Required Licensed Health Practitioner's Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed and recorded in accordance with the items specified on this form. At time of the exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

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

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

_____

_____

Print Name	MD/APRN/NP Signature	Date
Address	Phone	Fax

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

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.

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

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Practitioner) 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				
Other							

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner Use Only.

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

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

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

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

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner or Health Official.

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

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

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

District of Columbia Oral Health (Dental Provider) Assessment Form

Parent/Guardian Instructions:
Part 1: Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
Part 2: By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

Part 1: Child's Personal Information (to be completed by the parent/guardian)

Child's Last Name:	Child's First & Middle Name:	Date of Birth: MM/DD/YYYY	Gender: ❑ M ❑ F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: ❑ Home ❑ Cell ❑ Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: ❑ Home ❑ Cell ❑ Work	Emergency Contact:		Telephone:
Race Ethnicity: ❑ White Non-Hispanic ❑ Black Non-Hispanic ❑ Hispanic ❑ Asia or Pacific Islander ❑ Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: ❑ Medicaid ❑ Private Insurance ❑ None ❑ Other		

Part 2: Required Parent/Guardian Signatures

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

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

Dental Provider Instructions:
Part 3: Circle Yes or No in findings column. For Yes, please explain in Comments Section.
Part 4 Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

Part 3: Child's Findings and Parent Recommendations (please indicate in findings column)

CONFIDENTIAL FORM

	Findings	Comments
Gingival inflammation	Y N	
Plaque and/or calculus	Y N	
Abnormal gingival attachments	Y N	
Malocclusion	Y N	
Treated Dental Caries	Y N	
Untreated dental caries	Y N	❑ Check box if Urgent
Sealants on permanent molars	Y N	
Cleft lip and palate	Y N	
Preventative services completed	Y N	What kinds of preventative services were completed? ❑ Prophy ❑ Fluoride ❑ Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ❑ is completed ❑ is not completed ❑ under treatment ❑ refused treatment ❑ not necessary.
The child has ongoing ❑ urgent ❑ non-urgent treatment needs and is under treatment ❑ by me or ❑ has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: Phone: Date:

District of Columbia Health Certificate:
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.

D.C. Residency Verification Guide

2017-18 School Year

- **How can I show my D.C. Residency?**
  1. Collect documentation of your address. The document(s) **must** have your **current address** and your **name**. The documents must belong to the same person (i.e., both belong to Mom or Dad, not one from each parent).
  2. The person whose name is on the documents must bring them in-person to the school.
  3. When you bring the documents to the school, you will sign a simple form stating that you are the legal caregiver for our student and that you have not falsified any of the documents.

- **What documents can I use for residency verification?**

  There are several documents that can be used to show D.C. Residency. Choose **one** from List A or **two** from List B.

- **I don't have the right documents. What should I do?**

  Call Ingenuity Prep at (202) 562-0391 as soon as possible for additional assistance. We are not able to extend the enrollment deadline for missing residency documents.

List A Provide **one** of these documents	**List B** Provide **two** of these documents
Pay stub from the last 45 days, showing your D.C. address AND D.C. taxes	**D.C. car registration** that has not expired
Financial assistance from D.C. Government such as TANF, Medicaid, or housing assistance from the last 12 months	**Lease agreement AND receipt of rent payment** dated within the last two months
Supplemental Security Income showing current benefits, dated in the last 12 months	**D.C. Driver's License or government-issued ID**
Tax information authorization form D-40 for the previous tax year	**One utility bill with proof of payment** dated in the last 2 months
Military Housing Orders or DEERS statement, as long as the student's name is on the form	
Proof that the student is a ward of D.C.	
Embassy letter dated on or after April 1, 2017	