INGENUITYPREP

New Student Enrollment Packet

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

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

- ☐ Complete IP Enrollment Forms
  (Online only — See page 2 of this packet)
- ☐ Complete D.C. Residency Verification
  (Email or PowerSchool Enrollment Upload — See page 3)
- ☐ Submit health documents and birth certificate
  (Online only — See pages 14-20)
- ☐ Attend a New Parent Meeting in April or May
  (Online via Zoom only)

Your student is officially enrolled for the

2024-2025

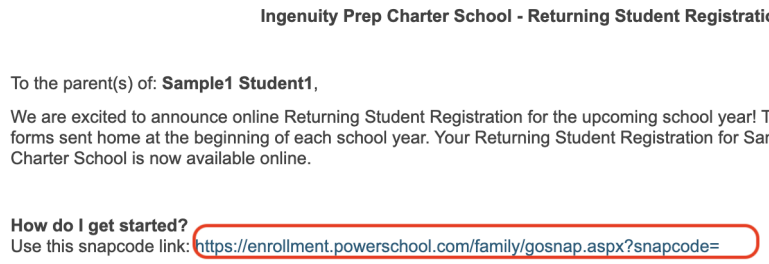
school year at Ingenuity Prep!

Deadline: May 1, 2024

PowerSchool Enrollment Instructions

1. Locate the registration email sent to you with the subject line: Ingenuity Prep Charter School New Student Registration

2. Click on the web address contained in the registration email



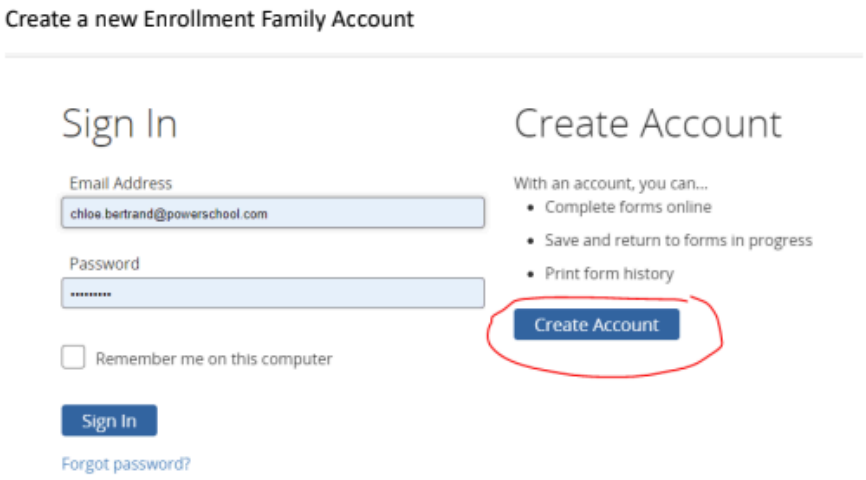
Ingenuity Prep Charter School - Returning Student Registration

To the parent(s) of: **Sample1 Student1**,

We are excited to announce online Returning Student Registration for the upcoming school year! This process replaces the paper forms sent home at the beginning of each school year. Your Returning Student Registration for Sample1 Student1 at Ingenuity Prep Charter School is now available online.

How do I get started?
Use this snapcode link: https://enrollment.powerschool.com/family/gosnap.aspx?snapcode=

3. Create your account



4. Complete all required fields in the registration forms and upload documents

Deadline May 1, 2024

D.C. Residency Verification Guide
2024-2025 School Year

All residency documents should be submitted by emailing the documents to admissions@ingenuityprep.org or uploaded to PowerSchool Enrollment.

- **How can I show my DC 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 to Dad, not one from each parent).
  2. Only parents or legal guardians may submit D.C. residency.
  3. The person whose name is on the documents must submit them to the school by email at admissions@ingenuityprep.org.
  4. When we have received and approved your documents, you will receive an e-signature form to complete, stating that you are your student's legal caregiver and have not falsified any of the documents.
- **What documents can I use for residency verification?**
  Choose one from List A or two from List B in the chart below.
- **I don't have the right documents. What should I do?**
  For additional assistance, email Mr. Jaxon at jpryor@ingenuityprep.org as soon as possible. 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 only (No other states can be shown on the pay stub)	**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 1 full month rent payment** with the receipt 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 2023, certified by the Office of Tax and Revenue	**One utility bill (gas, water, electric) with separate proof of payment** dated in the last 2 months
Military Housing Orders or DEERS statement	
Proof that the student is a ward of D.C.	
Embassy letter dated on or after April 1, 2024	
Online Tax Verification is available for families who have paid their 2023 taxes. Please ask Mr. Jaxon for more information about using this option.	
Pre-Verified by DC Government. Families who qualify for this option will be notified.	

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

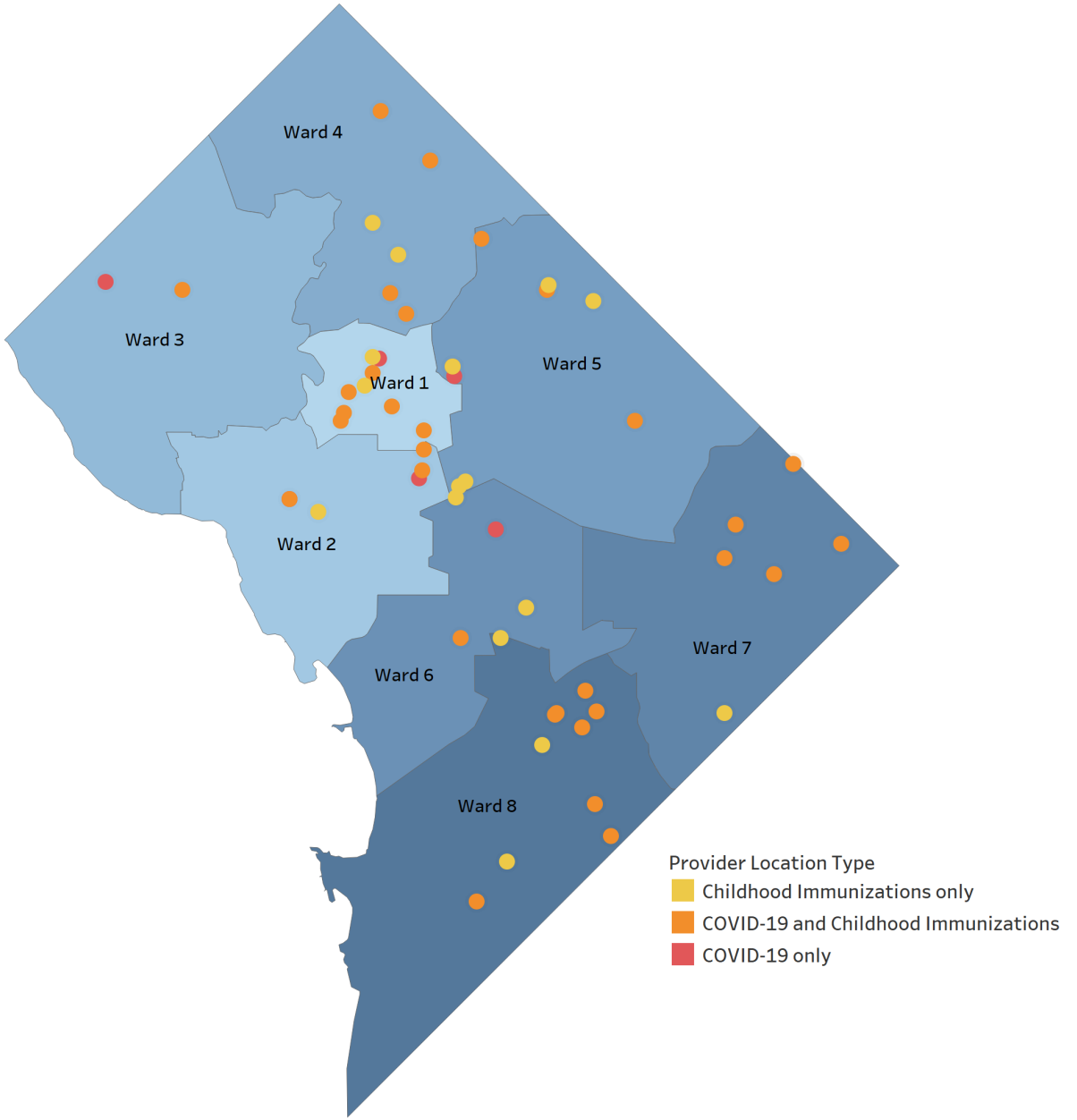
***Your Pre-K3 child may become eligible for a booster dose of vaccines against MMR, Chickenpox, Polio, and Diptheria/Tetanus/Pertussis when they turn 4 years of age. We highly encourage getting these on time, however these will not count against the attendance requirement mid-year.**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

2023 District Pediatric Vaccine Locations

Revised as of April 14, 2023

COVID-19 and Childhood Immunization Provider Map



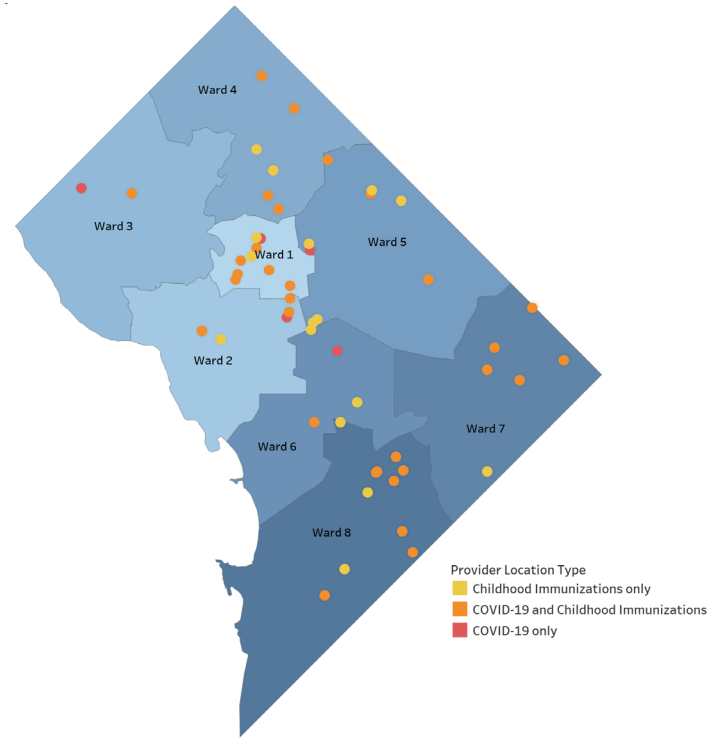
DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia – Pediatric Immunization Locations

By WARD

- WARD 1
- WARD 2
- WARD 3
- WARD 4
- WARD 5
- WARD 6
- WARD 7
- WARD 8



DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DC HEALTH
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WARD 1 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 1	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/Self-Pay)
Ahold Giant Pharmacies	1345 Park Road NW 20010	(202) 777-1078	**Mon-Th** 9am-9pm / **Sat** 9am-6pm / **Sun** 10am-5pm	✓	X	✓
Cardozo HS Health Center*	1200 Clifton St NW #C130 20009	(202) 727-5148	**Mon-Fri** 8am-4:30pm	✓	✓	✓
Children's Health Center Columbia Heights	3336 14th St NW 20010	(202) 476-5580	**Mon-Sat** 8am-4pm	X	✓	✓
Children's National Shaw Metro	641 S Str NW 2nd Fl 20001	(202) 476-2123	**Mon-Fri** 8am-4pm / **Sat** 8am-4:30pm	✓	✓	✓
Community of Hope Marie Reed Health Center	2155 Champlain St NW 20009	(202) 540-9857	**Mon** 8:30am-5pm / **Tues** 8:30am-7pm / **Wed** 8:30am-7:30pm / **Th & Fri** 8:30am-5pm / **Sat** 9am-3:30pm	✓	✓	✓
Howard University Family Practice	2041 Georgia Ave NW #3300 20060	(202) 865-6100	**Mon-Fri** 8:30am-5pm	✓	✓	✓
La Clínica del Pueblo	2831 15th St NW 20009	(202) 462-4788	**Mon-Fri** 10am-4pm	X	✓	✓
Mary's Center Ontario Road	2333 Ontario Rd 20009	(844) 796-2797	**Mon-Fri** 9am-5pm	✓	✓	✓
Unity Health Care Columbia Heights	1660 Columbia Rd NW 20009	(202) 469-4699	**Mon-Th** 8am-8pm / **Fri** 8am-5pm / **Sat** 8am-Noon	✓	✓	✓
Unity Health Care Upper Cardozo	3020 14th St NW #203 20009	(202) 469-4699	**Mon-Fri** 8am-10pm / **Sat** 8am-2pm	✓	✓	✓

***School-Based Health Center access is limited to currently enrolled students. Please call to confirm accessibility when scheduling an appointment.**

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WARD 2 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 2	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Ahold Giant Pharmacies	1400 7th St NW 20001	(202) 238-0181	**Mon-Th** 9am-9pm / **Sat** 9am-6pm / **Sun** 10am-5pm	✓	X	✓
Bread for the City	1525 7th St NW 20001	(202) 265-2400	**Mon-Th** 8:30am-5pm / **Fri** 8:30am-Noon	✓	✓	✓
Children's Pediatricians & Associates - Foggy Bottom	2021 K St NW #800 20006	(202) 833-4543	**Mon-Fri** 8am-5pm / **Sat** 9am-Noon	X	✓	✓
Michelle Barnes Marshall MD PC	2440 M St NW #317 20037	(202) 775-0051	**Mon-Th** 9am-5pm / **Fri** 9am-1pm	✓	✓	✓
West End Pediatrics	2440 M St NW #322 20037	(202) 758-3210	**Mon-Fri** 9am-5pm / **Sat (1st and 3rd of the month)** 9am-1pm	✓	X	✓

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WARDS 3 – 4 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 3	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Georgetown Kids Mobile Medical Clinic/Ronald McDonald Care Mobile	Mobile Clinic	(202) 444-8888	Please Call for Appointments, Days, and Hours	✓	✓	✓
MedStar Georgetown Pediatrics and Gynecology at Tenleytown	4200 Wisconsin Ave NW 4th Floor 20016	(202) 243-3400	**Mon-Th** 8am-7pm / **Fri** 8am-6pm / **Sat** 9am-Noon (by appointment only)	✓	✓	✓
Spring Valley Pediatrics	4850 Massachusetts Ave NW #200 20016	(202) 966-5000	**Mon-Fri** 9am-5pm	✓	X	✓
Facility – Ward 4	**Address**	**Phone**	**Office Hours**	**COVID Vaccine**	**Childhood Immunizations (Medicaid Eligible)**	**Childhood Immunizations (Private/ Self-Pay)**
Children's Medical Care Center	5425 14th St NW 20011	(202) 291-0147	**Mon-Fri** 8am-4:30pm	X	✓	✓
Children's National Shepherd Park	7125 13th Place NW 20012	(202) 545-2900	**Mon-Sat** 8am-4pm	✓	✓	✓
District Urgent Care	4903 Georgia Ave NW 20011	(202) 723-0393	**Mon-Fri** 9am-6pm	X	✓	✓
Mary's Center Georgia Avenue	3912 Georgia Ave NW 20010	(844) 796-2797	**Mon-Fri** 9am-5pm	✓	✓	✓
MedStar Health Roosevelt HS*	4301 13th St NW 20011	(202) 724-4086	**Mon-Fri** 8:30am-4:30pm	✓	✓	✓
Mary's Center SBHC Coolidge HS*	6315 5th St NW 20011	(202) 698-1383	**Mon-Fri** 8:30am-4:30pm	✓	✓	✓
Safeway Pharmacy	3830 Georgia Ave NW 20011	(202) 722-4067	**Mon-Fri** 9am-7pm / **Sat** 10am-4pm (until July 29)	✓	X	✓

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DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WARD 5 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 5	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
CNMC Dunbar High SBHC*	101 N St NW 20011	(202) 724-4086	**Mon-Fri** 8:30am-4:30pm	X	✓	✓
Children's National Health Center Pharmacy	111 Michigan Ave NW 20010	(202) 986-1467	**Mon-Fri** 8am-9pm / **Sat & Sun** 10am-6pm	✓	X	✓
Community of Hope Family Health and Birth Center	2120 Bladensburg Rd NE 20018	(202) 540-9857	**Mon, Wed, Th, & Fri** 8:30am-5pm / **Tues** 8:30am-7:30pm / **Sat** 9am-3:30pm	✓	✓	✓
CuraCapitol Clinical	1140 Varnum St NE #208-B 20017	(202) 930-2380	**Mon-Fri** 8am-5pm / **Sat** 10am-4pm	✓	✓	✓
Dr. Marjorie McKnight / Lisa Banner	106 Irving St NW #2300 20010	(202) 291-6257	**Mon-Fri** 7am-4pm	✓	✓	✓
Pediatric Center - Hospital for Sick Children Pharmacy	1731 Bunker Hill Rd NE 20017	(202) 832-4400	**Mon-Sun** 9am-5pm	X	✓	✓
Mary's Center Fort Totten	100 Gallatin St NE 20011	(202) 847-4387	**Mon-Fri** 9am-5pm	✓	✓	✓
Pediatric Professionals PC	106 Irving St NW #306 20010	(202) 854-0052	**Mon** 7:30am-6pm / **Wed** 8am-4:30pm / **Tues, Th & Fri** 7:30am-5pm / **Sat** 9am-2pm	X	✓	✓
Providence Family Medicine	1160 Varnum St NE #110 20017	(202) 854-4090	**Mon-Fri** 8am-4pm	X	✓	✓
SOME (So Others Might Eat)	60 O St NW 20001	(202) 797-8806	**Mon-Fri** 8:30am-3:30pm	X	✓	✓
The McCuiston Group	106 Irving St NW #218 20010	(202) 291-6257	**Mon-Fri** 7am-4pm	✓	✓	✓
Unity Health Care - Brentwood Square	1251-B Saratoga Ave NE 20018	(202) 832-8818	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm	✓	✓	✓

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DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

WARDS 6 - 7 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 6	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Children's Pediatricians & Associates – Capitol Hill	650 Pennsylvania Ave SE #C-100 20003	(202) 833-4543	**Mon-Fri** 8am-5pm / **Sat** 9am-Noon	X	✓	✓
Community Concierge Care – Greenleaf	1200 Delaware Ave SW #3 20024	(202) 888-6440	**Mon-Fri** 9am-5pm	✓	✓	✓
Kaiser Permanente Capitol Hill	700 Second St NE 20002	(202) 346-3000	**Mon-Fri** 9am-5pm	✓	X	✓
Providence Perry Family Health Center	128 M St NW #50 20001	(202) 854-3840	**Mon-Fri** 8am-5pm	X	✓	✓
Unity Health Care – Southwest	850 Delaware Ave SW 20024	(202) 469-4699	**Mon-Fri** 8am-5pm	✓	✓	✓
Safeway Pharmacy	415 14th St SE 20003	(202) 920-5870	**Mon-Fri** 8am-8pm / **Sat** 9am-6pm / **Sun** 10am-5pm	X	✓	✓
Safeway Pharmacy	490 L St NW 20001	(202) 719-2435	**Mon-Fri** 9am-7pm / **Sat** 10am-4pm (until July 29)	✓	X	✓
Facility – Ward 7	**Address**	**Phone**	**Office Hours**	**COVID Vaccine**	**Childhood Immunizations (Medicaid Eligible)**	**Childhood Immunizations (Private/ Self-Pay)**
Children's Pediatricians & Associates – Ft. Davis	3839 1/2 Alabama Ave SE 20020	(202) 582-6800	**Mon-Fri** 8am-4pm / **Sat** 8am-Noon	X	✓	✓
Elaine Ellis Center of Health	1627 Kenilworth Ave NE 20019	(202) 803-2350	**Mon & Wed** 9am-6pm / **Tues & Th** 9:30am-7pm / **Fri** 9:30am-2pm / **Sat (4th of the month)** 9:30am-2pm	✓	✓	✓
Unity Health Care – East of the River	4414 Benning Rd NE 20019	(202) 469-4699	**Mon-Fri** 8am-5pm	✓	✓	✓
Unity Health Care – Minnesota Ave	3946 Minnesota Ave NE 20019	(202) 469-4699	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm / **Sun (2nd & 4th of the month)** 8am-2pm	✓	✓	✓
Unity Health Care – Parkside	765 Kenilworth Terrace NE 20019	(202) 469-4699	**Mon-Fri** 8am-9pm	✓	✓	✓
Unity Health Care – Woodson HS Health Center*	540 55th St NE #W101 20019	(202) 469-4699	**Mon-Fri** 8am-4:30pm	✓	✓	✓

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DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WARD 8 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility	Address	Phone	Office Hours	COVID Vaccine	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Bread for the City	1700 Good Hope Rd SE 20020	(202) 561-8587	**Mon-Th** 9am-5pm / **Fri** 9am-Noon	✓	✓	✓
Children's Health Center Anacostia	2101 MLK Jr Ave SE 5th Fl 20020	(202) 476-6900	**Mon-Th** 8am-8pm / **Fri & Sat** 8am-4pm	✓	✓	✓
Children's Health Center at THEARC	1801 Mississippi Ave SE 20020	(202) 436-3060	**Mon-Th** 8am-8pm / **Fri & Sat** 8am-4pm	✓	✓	✓
Community of Hope Conway Health and Resource Center	4 Atlantic St SW 20032	(202) 540-9857	**Mon, Tues, Wed, & Fri** 8:30 am-5pm / **Th** 8:30am-7pm / **Sat** 9am-3:30pm	✓	✓	✓
Children's Health Center – Goldberg SBHC Ballou High School*	3401 4th St SE 20032	(202) 645-3843	**Mon-Fri** 8:30am-4:30pm	X	✓	✓
Core Health & Wellness Center	2516 Sheridan Road SE #A 20020	(202) 610-6103	**Mon-Fri** 9am-3pm / **Sat** 9am-2:30pm	X	✓	✓
Family and Medical Counseling Service	2041 MLK Jr Ave SE #206 20020	(202) 889-7900	**Mon-Fri** 8am-5pm	✓	✓	✓
GW Health @ Cedar Hill Urgent Care	2228 MLK Jr Ave SE 20020	(202) 715-4444	**Sun-Sat** 8am-8pm (until July 28)	✓	X	✓
Healthy Horizon Assessment Center	200 I St SE 1st Fl 20003	(202) 442-6100	**Mon-Fri** 8:15am-4:45pm	X	✓	✓
MedStar Health – SBHC Anacostia*	1601 16th St SE 20020	(202) 724-5529	**Mon-Fri** 8:30am-4:30pm	✓	✓	✓
Unity Health Care – Anacostia	1500 Galen St SE 20020	(202) 469-4699	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm	✓	✓	✓
Unity Health Care – Stanton Road	3240 Stanton Rd SE 20020	(202) 469-4699	**Mon-Fri** 8am-8pm	✓	✓	✓

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DC HEALTH 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				
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

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

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.** ☐ 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:

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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.

SCHOOL HEALTH SERVICES PROGRAM

Please fill out the form below after carefully reviewing the policies and procedures governing student health services, and then sign the required consents contained in this document. This is required in order for you (if you are a student who is 18 years of age or older) or your child to participate in the School Health Services Program. Please submit the completed document to your child's school registrar.

Student's Personal Information | Completed by parent/guardian/student eighteen (18) years of age or older				
Student Last Name:		**Student First Name:**		**Date of Birth:**
School or Child Care Facility Name:				
Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**
Ethnic Designation: *(check all that apply)* ☐ Hispanic/Latino ☐ Other ☐ Non-Hispanic/Latino ☐ Prefer not to answer				
Race: *(check all that apply)* ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Prefer not to answer				

Parent/Guardian Information			
Parent/Guardian Name 1:		**Parent/Guardian Name 2:**	
Phone:	**Email:**	**Phone:**	**Email:**
Relationship to Student:		**Relationship to Student:**	
Parent/Guardian Phone:		**Parent/Guardian Phone:**	
Emergency Contact Name, Relationship to Student:		**Emergency Contact Phone:**	

Insurance Information	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:** **Insurance Plan:**
If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance? ☐ Yes ☐ No	
Primary Care Provider Name:	
Primary Care Provider Organization & Address:	
Primary Care Provider Phone:	

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SCHOOL HEALTH SERVICES PROGRAM POLICIES AND PROCEDURES

- Students may receive care from a school nurse, school health suite personnel, or trained school staff in accordance with District of Columbia (District) laws and regulations and the District's Department of Health (DC Health) School Health Services Program (SHSP) policies and procedures.
- I understand in order to participate in the SHSP, I must provide consent to allow the student's medical care provider to electronically send my child's health information including, but not limited to the information in the Universal Health Certificate, to my child's school. Information regarding care provided to my child in my child's school may be shared with other District agencies for the purpose of coordinating my child's care and for District-wide data collection, for example to monitor asthma or other health trends in the District.
- My child's health information will always be stored and transferred in accordance with District and federal laws and regulations including, but not limited to the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) act and D.C. Law 18-273, the Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Official Code § 7-241 et seq.)
- A student that is eighteen (18) years of age or older, or an emancipated minor, as defined by D.C. Official Code sec. 7-1231.02 (10) may complete this form for themselves and legally consent to any school health services.
- In accordance with the Minor's Health Consent Regulation (22-B DCMR 600.7) for a minor may legally consent for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered.

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SCHOOL HEALTH SERVICES PROGRAM ACKNOWLEDGEMENTS AND CONSENTS

- I hereby give consent for my child's school or school health suite personnel to provide a hearing and vision screening test if my child has not received one in the past calendar year according to their submitted Universal Health Certificate.
- I hereby give consent for the school or school health suite personnel to administer prescribed medication and/or treatment to my child as directed by my child's licensed healthcare provider, in accordance with D.C Official Code § 38-651 and in emergency circumstances, in accordance with D.C Official Code § 38-656.

I understand:

- I am responsible for submitting school health forms including but not limited to: Medication and Medical Procedure Treatment Plan, Asthma Action Plan, Anaphylaxis Action Plan, Dietary Accommodation Form or other accepted school health form signed by my child's medical provider to my child's school if my child needs special medical care or medication. I am responsible for submitting an updated school health form annually for my child.
- I am responsible for bringing any needed medication or medical supplies listed on a complete school health form, in their original packaging, to the school nurse. All medication or medical supplies will be stored in a secured area of the school.
- I am responsible for collecting all expired medication kept at school within one week of its expiration date and within one week of the end of the school year. I understand that uncollected medication will be destroyed. Health suite personnel do not assume any responsibility for possible loss of medication or medical supplies.
- I am responsible for immediately notifying the school if any changes occur in the education and Medical Procedure Treatment Plan and providing all updated school health forms to the school. The health suite personnel can be reached by calling the health suite directly or by calling the school's main phone number.
- I understand that the school or school health staff will not assume any responsibility for my child's unauthorized self-medication or treatments. My child may only self-treat or self-administer medication for asthma, anaphylaxis or diabetes if they are approved to self-medicate as directed by a licensed medical provider and in line with a complete school health form.
- I hereby acknowledge and agree that, as provided for in D.C. Official Code sec. 38-651.11, the District, the school, its employees and agents (including school nursing staff) or the practicing physician, physician assistant or advanced practice nurse, who has issued a standing order shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code sec. 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form must be completed and submitted before the student can receive health services.

Student Name (printed)_____ Parent/Guardian Name (printed)_____

Parent/Guardian Signature/Student if age is 18 or older _____ Date _____

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SCHOOL HEALTH SERVICES TELEHEALTH PROGRAM TERMS AND CONDITIONS

The School Health Services Telehealth Program allows students to be seen remotely at their school by a medical care provider. By signing below, I understand, acknowledge and agree that:

- My child may participate in appointments conducted by video (videoconferencing) or phone call (teleconferencing) with healthcare providers such as behavioral health providers who may be at an off-school location. The healthcare provider may determine that an in- person follow-up visit or that urgent care or emergency services is required.
- In addition to my child's healthcare team and provider, individuals who operate the video equipment and who are trained to maintain the confidentiality of all information obtained may also be present. The student has the right to request that: (1) specific details of their medical history/physical examination be omitted; (2) non-medical personnel leave the examination room; or (3) the visit be terminated at any time.
- I have the option to refuse a telehealth appointment for my child.
- I authorize the provider or its healthcare personnel to release any and all information to my child's health insurance plan or any other agent that may be responsible for paying medical bills associated with the visit. I further authorize the School Health Services Telehealth Program to release specific medical information to school officials and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.
- My insurance may be billed for Telehealth services. I understand I am responsible for providing insurance information and am responsible for any additional copay or charge resulting from this service. Enrollees in any DC Medicaid Managed Care Organization will not receive a bill for any of the services provided through telehealth. All charges associated with this program are at the discretion of the insurance company. Any copay that is required for primary care visits could apply for this service. I understand that any monies or benefits for providing telehealth will be assigned and transferred to the provider, including benefits/monies from my health plan, Medicaid, or other third parties who are financially responsible for my child's medical care. I authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes.
- If I am not satisfied with the services rendered at any time, I may file a complaint with the Ombudsman team via phone: (202) 724-7491 or via email: healthcareombudsman@dc.gov. Complaints should also be submitted via the School Health Services Program portal at: https://dchealth.force.com/studenthealthservices/s/.
- This consent will be valid for the duration of the student's enrollment in the school. I also understand that I have the right to withdraw my consent at any time by giving the health suite staff a signed and dated letter withdrawing my consent.

Student Name (printed)_____ Parent/Guardian Name (printed)_____

Parent/Guardian Signature/Student if age is 18 or older _____ Date _____

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