Civilian

USCG HQ's Child Development Center
Instructions for Completing Enrollment Application & Process for Entering the CDC

1. Immediately upon your acceptance of a slot your tuition payment is due to include a $25 registration fee even if you decide not to bring your child in on the actual start date. Checks are written out to USCG MWR.

2. The Enrollment Package must be completely filled out to include all medical paper work and notarized forms before your child can start. These forms must be renewed every year. Please initial any corrections you make on the forms. **Deliberate misrepresentation or fraudulent information provided on these documents may subject you to termination of services.**

3. **Release of Information/Privacy Act Statement:** Supplying of the requested information is voluntary. Failure to respond will result in the denial of admission of your child to the program.

4. **Child's Health Forms:** The CG CDS Child Health Form (physical), District of Columbia Child Health Certificate & Dental Assessment Form (for children 3 and over) and the Allergy form must be **truthfully and *completely filled out, signed, stamped, and dated by the physician*** in all applicable spaces.

(a). **All children enrolled in centers located in the District of Columbia are required to have a TB test and Lead Test(not screening) at one year of age. Children one year and older entering the center must have proof of these tests being done prior to your enrollment. There will be no exceptions. Please notify the CDC of any special needs your child may have prior to their enrollment.**

(b). All children must have a current physical within two months prior to admission for children six months of age and younger; within three months prior to admission for children aged seven months through 18 months; within six months prior to admission for children aged 19 months through 24 months; within 12 months prior to admission for children two years of age through five years of age; within 12 months prior to enrollment.

5. **The Medical Consent Authorization Form:** This CG form authorizes the CDC staff to obtain medical treatment for your child in the case of an emergency. **This form must be notarized**. It is valid for 1 year only and should expire exactly one year after the date it is signed. This form can only be filled out by the parent or legal guardian of the child. **Military members are required to have the Chief Medical Administration Branch, Health Services Division Chief sign the form.** The DC Authorization for Child's Emergency Medical Treatment form does not need to be notarized.

6. **District of Columbia Registration Form:** The person to be contacted in case of an emergency cannot be yourself or your spouse. Please use a family member, co-worker, friend etc. that lives in the local vicinity.

(a). Please provide us with at least two working phone numbers for each individual you use as a contact person. The CDC will always call the parents of the child first if there is an emergency. We will only use this person if you can not be reached.

(b). The designated individual authorized to receive your child for departure must be someone other than you or your spouse. Again, this is for instances when you personally cannot come pick up your child. Please note that that we will note release your child to someone that is not on file.

7. **Developmental History Form:** Please give us as much detailed information as you can in order for us to gain as much knowledge as possible about your child prior to their enrollment. We would like to care for all of your child's needs to the best of our ability. The more information you provide, enables us to do this more efficiently.

8. **Field Trip Permission Form:** This form gives the CDC permission to take your child outside to the playground, for a walk at Ft. McNair, or in the immediate vicinity. This form does not give staff permission to take you child on an actual "field trip" to another location. A separate form will be filled out for special field trips.

RELEASE OF INFORMATION/PRIVACY ACT STATEMENT

Data required by the Privacy Act of 1974 (5 U.S.C. 552a)

Authority:	14 U.S.C. 632
Principle Purposes:	To provide the care providers with authorization for medical treatment in emergency situations, identify children and sponsor, record required immunizations and known allergies, and to provide other information necessary for working with the child.
Routine Purposes:	Form may be furnished to military or civilian doctor or hospitals in the course of obtaining medical treatment for children. Information furnished may be disclosed to any DHS component or part thereof, and upon request to other Federal, State, and local governmental agencies in the pursuit of their official duties.
Disclosure is Voluntary:	The supplying of requested information is voluntary. Failure to respond will result in the denial of admission of your child to the program.

I release the information on the attached registration forms to the provider of child care services for the purpose of assessing the eligibility of the child(ren) for the program and for the routine uses listed above.

_____ _____

(Date) (Signature)

C&RCFD 045 REV 07/04

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION

DEPARTMENT OF HEALTH

PLEASE PRINT OR TYPE

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home # _____

Home Address: _____
Number Street Apt. # State ZIP

Father: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Mother: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

Date of Withdrawal: _____ **Reason:** _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

C&RCFD 046 REV 07/04

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, date of birth _____,
month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ Telephone No: _____
M.D./N.P. (Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caretaker

_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ☐ DC ☐ MD ☐ VA

Child's Known Allergies or Health Conditions: Yes ☐ No ☐
(If yes, explain here: _____

_____

_____

Home Address: _____
Street City/State Zip Code

Area Code/Telephone No: _____ _____ _____
Home Business Pager/Cell Phone

Signature: _____

Relationship to Child: _____

Date: _____
month/day/year

PLEASE RETAIN A COPY FOR YOUR RECORDS

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-5484I (Rev. 04-05)	**CHILD DEVELOPMENT SERVICES** MEDICAL CONSENT AUTHORIZATION (TO BE USED BY **CIVILIAN** FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

TO: **HEALTH CARE PROVIDER**

I, _____ , am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: _____ , Age: _____

Address: _____ , Phone: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____ (Insured Person's Name) _____ (Employee ID #) _____ (Employer Name)

_____ (Employee Address)

_____ (Insurance ID Card #) _____ (Insurance Effective Date)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the _____ Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____ , 20 _____ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on _____ , 20____.

_____
Signature of Parent or Guardian

_____
Date

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-5484A (Rev. 04-05)	**CHILD DEVELOPMENT SERVICES** CHILD HEALTH FORM

To be completed by a health practitioner before admission to a child care program and renewed annually.

_____ has had a complete history and physical examination at my office on
(Child's name: Last/First/Middle)

_____ . Findings for this child are indicated as follows:
Date

1. Date of most recent tuberculin test _____ . Result: Positive _____ Negative _____

2. The child has the following which may significantly affect his education/care experience:

	YES	NO	COMMENTS
a. Visual problem	_____	_____	_____
b. Hearing problem	_____	_____	_____
c. Speech or language problem	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional, behavior problem	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments, and recommendations:

3. YES / NO The child has a health condition, which may require care or emergency action while he is at child care. (Please specify, e.g., seizures, bee sting allergy, diabetes, etc.)

Recommendations:

4. YES / NO The child has or is a known carrier of a communicable disease.

Explain:

5. YES / NO The child is on long term medication. Specify:

6. YES / NO The child requires a modified diet and/or special feeding procedures. Specify:

7. YES / NO The child is in good physical and mental health. Except as noted above, he is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

8. If child cannot fully participate in all areas of child care program, what areas should be limited or altered to suit this child's needs?

9. YES / NO Does child's physical activity need to be restricted? If YES, explain

10. What specialized treatments, if any, will this child require?

    Instructions for care:

11. Does this child require any supportive equipment? (Braces, crutches, etc.) YES NO

    If YES, please specify type _____

    Special instructions for use _____

12. Additional comments:

SIGNATURE & STAMP REQUIRED

_____

Health Practitioner **(please print)** Phone

_____

Signature of Health Practitioner Date

_____

Address

CONFIDENTIAL FORM- SIDE ONE

Please review instruction on side two prior to completing form

DISTRICT OF COLUMBIA CHILD 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	Telephone1: ☐ Home ☐ Cell ☐ Work	Home Address:		Ward
Emergency Contact:	Telephone2: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zipcode:
School or child care facility:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____			Primary Care Provider (PCP):

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

DATE OF HEALTH EXAM:	WT	☐ LBS ☐ KG	HT	☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	HGB / HCT *(Required for Head Start)*

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Dental-Oral Health	☐ None	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ None	☐ YES	☐ Referred ☐ Under Rx
Asthma	☐ None	☐ YES	☐ Referred ☐ Under Rx	Vision	☐ None	☐ YES	☐ Referred ☐ Under Rx
Development	☐ None	☐ YES	☐ Referred ☐ Under Rx	Hearing	☐ None	☐ YES	☐ Referred ☐ Under Rx
Behavioral/Emotional	☐ None	☐ YES	☐ Referred ☐ Under Rx	Nutrition	☐ None	☐ YES	☐ Referred ☐ Under Rx
Learning/Attention	☐ None	☐ YES	☐ Referred ☐ Under Rx	Neurologic	☐ None	☐ YES	☐ Referred ☐ Under Rx

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

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

B. Significant allergies or health conditions that may require ***emergency medical care*** at school, childcare, camp, or sports activity.
☐ NONE ☐ YES, please detail:

C. Long-term Medications or special care requirements or accommodations.
☐ NONE ☐ YES, please detail: (Please specify medication dosage/time/administration instructions and common side effects if given at school/child care)

This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or childcare activities except as noted above. **ATHLETE IS CLEARED FOR COMPETITIVE SPORTS: ☐ YES ☐ NO**

Part 3: Immunization Information: ***(Please fill in or attach equivalent copy with provider signature and date)***

Diphtheria-Tetanus-Pertussis (< 7 yrs)	DTP/DTaP-1	DTP/DTaP-2	DTP/DTaP-3	DTP/DTaP-4	DTP/DTaP-5
Diphtheria-Tetanus (DT <7 yrs must have P exemption) (Td >7 yrs) Tetanus-diphtheria-acellular pertussis (Tdap)	DT/Td -1 / Tdap -1	DT/Td -2	DT/Td -3	DT/Td -4	DT/Td-5
Haemophilus Influenzae B (HIB)	HIB1	HIB2	HIB3	HIB4	
Hepatitis B (HBV)	HBV1	HBV2	HBV3		
Polio	OPV/IPV- 1	OPV/IPV- 2	OPV/IPV-3	OPV/IPV- 4	
Measles-Mumps-Rubella (MMR)	MMR1	MMR2	Measles-1_____ Measles-2_____	Mumps-1_____ Mumps-2_____	Rubella-1_____ Rubella-2_____
Varicella	VZV1	VZV2	☐ Check if hx disease Disease date _____ (month/year)		
Pneumococcal conjugate (PCV7)	PCV7-1	PCV7-2	PCV7-3	PCV7-4	
Hepatitis A (HAV)	HAV-1	HAV-2			
Meningococcal (MCV4)	MCV-1				
Human Papillomavirus (HPV)	HPV-1	HPV-2	HPV-3		
Other					

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing If PPD Positive:

TB EXPOSURE RISKS? See reverse side for instructions.	☐ HIGH→ ☐ LOW	PPD TEST DATE:	☐ NEGATIVE ☐ POSITIVE	☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ **TREATED**	**Health Provider:** ALL POSITIVE PPD tests MUST BE Reported to T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS? See reverse side for instructions.	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-442-4827	

Part 5: Required Provider Certification and Signature

Age-Appropriate Health Screening Requirements Performed Within Current Year ☐ YES ☐ NO
If NO, please explain

_____

Medical Exemption From Immunization: I hereby certify that the student named above was not immunized against (disease) _____ because (reason) _____ (if applicable, attach serological test results). Date Exemption Expires: _____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, childcare, camp, or DOH

PRINT NAME	SIGNATURE	Date

Top Copy – School Nurse **2nd Copy – School** **3rd Copy – Parent** Revised 03/14/08

INSTRUCTIONS FOR USE-SIDE TWO **DISTRICT OF COLUMBIA CHILD HEALTH CERTIFICATE**

This form *replaces* all forms dated before February 25, 2004, used for entry into DC Schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form, formally the Dental Appraisal Form. This form was developed by the DC Department of Health and follows American Academy Of Pediatrics (AAP) Guidelines For Child And Adolescent Health Care Birth to 21 Years Of Age. **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 Educational Rights and Privacy Act* (FERPA) for the DC Schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's personal information:

Parent or Guardian: Please check the box that best fits the description of the child's race or ethnicity. Please indicate the ward of your home address. List primary care provider and type of health insurance coverage. If child has no provider or is uninsured, then please write "**None**" in each box. **This form will not be complete without parent or guardian signature in Part 5.**

Part 2: Child's health history, Examination & Recommendations: To be completed by the health care provider. Please mark all relevant boxes.

- **Date of complete health exam: All children MUST have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines.** The date entered here must indicate that the child is in compliance with these requirements outlined in DC Law 6-66.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG) **HT: Child's height in either inches (IN) or centimeters (CM)**
- **BP: If child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal please provide explanation and resolution in part 2 section "A."**
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is *required* For Head Start children. Anemia screen is recommended for menstruating adolescents based on AAP guidelines. Please record level and indicate by circling HGB or HCT.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens dental-oral health, asthma, development, behavioral/emotional, learning/attention, language/speech, vision, hearing, nutrition, and "neurologic disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO "HEALTH CONCERNS" then please mark the **'None'** Box in each screen area. **SPECIAL NOTE: 'Dental-Oral Health' refers to the screening done by a primary care provider. This does not replace a comprehensive oral examination provided by a dentist. For children age three and older the health care provider must also indicate whether dentist has screened or examined the child within the last 12 months. If no, child should be referred to dentist.**

A. Please note any significant health history, conditions, communicable illness, or restrictions that may affect the activity or program **OR mark 'NONE'.**
B. Please note any significant allergies or health conditions that may require ***emergency medical care*** at the activity or program **OR mark 'NONE'**
C. Please note any long-term medications or special care requirements or accommodations **OR mark 'NONE'**. (For medications that require administration at activity or program, please specify dosage/ timing / administration instructions and common side effects of each medication).

Athlete is cleared for competitive sports based on the assessment in the AAP Preparticipation Physical Evaluation 2nd Ed. (1997): Check YES or NO. This will cover patient for ALL YEARLY PHYSICALS for competitive sports.

Part 3: Immunization Information:

All areas of this section must be completed or an equivalent form attached with the physician's or health care provider's signature.

As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised 03/21/97), the following immunizations are required. Medical exemptions from immunizations may be granted for valid reasons with proper documentation and certified and signed by the health care provider in Part 5.

DOH Immunization Program: 202-576-7130

Summary of **REQUIRED** Cumulative Number of Doses of Vaccine for PRESCHOOL aged children[1] — Doses Must Be Appropriately Spaced and Given at Appropriate Age

Age of Child	DTaP/DTP/DT/Td[2]	Polio[3]	Hib[4]	Hepatitis B	Hepatitis A (born after 01/01/05)	Pneumococcal[7]	MMR[5]	Varicella[6]
Less than 2 Months	0	0	0	0	0	0	0	0
2-3 Months	1	1	1	1	0	1	0	0
4-5 Months	2	2	2	2	0	2	0	0
6-11 Months	3	3	3	3	0	3	0	0
12-17 months	4	3	3 or 4	3	2	4	1	1
18-60 Months	4	3	3 or 4	3	2	4	1	1

Summary of **REQUIRED** Cumulative Number of Doses of Vaccine for Children in GRADES KINDERGARTEN – 12[1] — Doses Must Be Appropriately Spaced and Given at Appropriate Age

Grade Level		DTaP/DTP/DT/ Td/Tdap[2]	Polio[3]	Hib[4]	Hepatitis B	Hepatitis A (born after 01/01/05)	MMR[5]	Varicella[6]	MCV ('09-'10 School Year)	HPV ('09-'10 School Year)
Grade	If Ungraded									
Kindergarten	(5 years)	5	4	Not required	3	2	2	2	0	0
Grades 1 & 2	(6-7 years)	5	4	Not required	3	2	2	2	0	0
Grades 3 - 5	(8-10 years)	5 doses or ≥ 3 doses Td	4	Not required	3	2	2	2	0	0
Grades 6 – 12	(11-18+ yrs)	5 doses plus Td/Tdap booster Or ≥ 3 doses OR if 10 years since last dose	4	Not required	3	2	2	2	1	3

All religious exemptions must be submitted to the school Principal & must be accompanied by a signed notarized statement from parent or guardian. Child care and Head Start children must obtain exemptions from child care or Head Start Director.

[2] DTaP/DTP/DT/Td: 5 doses of DTaP/DTP are required for school entry unless the fourth dose is given on or after the 4th birthday. Three (3) doses of Td required if primary series started after 7th birthday.
[3] Polio: Four doses are required for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which case only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are always required to complete the primary series. Polio not routinely required for students >18 years of age.
[4] Hib: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age; however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.
[5] MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and varicella must be given on the same day or separated by at least one month.
[6] Varicella: The varicella vaccine is not required for a student who has a reliable history of disease. Two doses are required for students 4 years old or older.
[7] Pneumococcal Vaccine: Recommended for all children age 2 to 23 months. The number of primary doses is determined by age series begins. The final dose in the series should be given at age > 12 months. It is also recommended for certain children age 24 to 59 months.

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing:

- **TUBERCULOSIS EXPOSURE RISKS?** Please assess risk of ALL patients for **Exposure to Tuberculosis** as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2003 AAP RED BOOK page 646.* **Current DC regulations require ONE** PPD (Purified Protein Derivative) Test for all children entering child care or school, whichever comes first. PPD Test is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note date of test and mark outcome of test (negative or positive). **IF PPD IS POSITIVE,** then mark outcome of chest X-Ray (CXR) and if child was treated. **ALL POSITIVE PPD tests MUST BE Reported to DC T.B. Control at 202-698-4040.**
- **LEAD SCREENING TESTS:** DC law requires that all children get tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6 years. Please document "Date" of most recent test and "Result." Please indicate if "Pending." "Pending" results will be **valid for two months from date of testing** and will NOT exclude child from activity or program. **ALL lead tests must be reported electronically by labs to DC Lead Poisoning Prevention Program. For detailed instructions, call 202-442-5876. Providers may fax to: 202-442-4827.**

Part 5: Required Provider Certification and Signature

All information will be kept confidential. A physician or nurse practitioner must complete this part. By checking the yes box the provider certifies that the child has received age-appropriate screenings according to AAP and EPSDT guidelines within the current year. If no is checked please explain reason in space provided.

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

- **The parent or guardian must print, sign, and date this Part.** By signing this section the parent or guardian gives permission to the health examiner or facility to share the health information on this form with the child's school, childcare, camp, DOH, or the entity requesting this document.

Forms are available online at www.doh.dc.gov

CONFIDENTIAL FORM- SIDE ONE

Please review instruction on side two prior to completing form

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender: ☐M ☐F	School or Child Care facility:
Parent/Guardian Name	Telephone1: ☐Home ☐Cell ☐Work	Home Address:		Ward
Emergency Contact:	Telephone2: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)		Zip code:
Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____				
Primary Care Provider (Medical):	Dentist/Dental Provider:	☐Medicaid ☐Private Insurance ☐None ☐Other_____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider) Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants
X - Missing teeth
● Restoration
|| Non-restorable/ Extraction
1D-One surface decay
UE- Unerupted Tooth
2D-Two surface decay
3D-Three surface decay
4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y N	
2. Plaque and/or Calculus	Y N	
3. Abnormal Gingival Attachments	Y N	
4. Malocclusion	Y N	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to _____		
DDS/DMD Signature	Print Name	Date
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or 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 or guardian	
SIGNATURE of parent or guardian	Date

Top Copy- School Nurse/DC Oral Health Program

2nd Copy- Oral Health Provider

Forms are available online at http://doh.dc.gov

7/18/2006

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. 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 all 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 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's Personal Information
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 coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.
Please use key to document all findings for each tooth. An '**X**' signifies a missing tooth (teeth) with no replacement; non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.

- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. Final Evaluation/Required Dental Provider Signature; 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 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date
The parent or guardian must print, sign, and date this part. 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 requesting this document. All information will be kept confidential.

US COAST GUARD HEADQUARTERS CHILD DEVELOPMENT CENTER
ALLERGY AND MEDICAL ALERT LIST

This form must be updated annually or as needed.

Child's Name_____**Date**_____

Allergic to what foods? What substance? Grass, Pollen…	Possible Negative Reaction or Medical Condition if exposed to the food or substance	Physician's Signature/Comments

Child has no known allergies at this time. ☐

Is the child currently on medication to alleviate reactions to the above allergy? ☐ **Yes** ☐ **No**

Please explain and document length of time child will be taking the medication:_____

_____

_____

_____

Physician's Signature & Stamp:_____**Date:**_____

FIELD TRIP PERMISSION

I give my permission for _____

(child care provider) to take my child(ren) _____

_____ (name) on field trips and/or other outings

as long as my child(ren) is/are accompanied by competent supervision. These

outings may be walking, motor vehicle, bicycle, etc.

The above authorization shall remain in effect for one (1) year from below date, or until cancelled or amended by parent or legal guardian.

_____ _____

(Signature of parent/legal guardian) (Date)

U.S. COAST GUARD CDC DEVELOPMENTAL HISTORY FORM

Child's Name:_____Nickname (if any):_____
Date of Birth:_____Sex:_____Phone #:_____
Address:_____

Having information about your child on file helps the staff understand and plan for his/her needs and interests. We also want to consider your ,views about your child, for you know your youngster most intimately. Therefore, your filling out this form will be mutually beneficial for everyone involved with his/her caring and development. From time to time we will request that you update the developmental information that you have provided, since young children change and grow very rapidly. This knowledge, as well as other data submitted by you, will be kept in strict confidence. Only with your permission would information about your family be forwarded to any other school or organization.

Family History:

What type of child care arrangements did you have prior to enrollment in the USCG CDC?(Example-parent at home, another childcare center, home care provider, etc.)
Please Explain:_____

_____

Health History:

Were there any complications at birth? Please Explain:_____

_____

_____

Does your child have a history of the following:
Frequent colds_____ Frequent Diarrhea_____ Asthma_____
Nosebleeds_____ Ear infection_____ Stomach aches_____
Seizures_____ Headaches_____ Urinary infection_____
Other_____
Please indicate what brings on the above condition(s) if you know:_____

_____

Does your child have allergies?_____ If so, how are they manifested?_____
Asthma_____ Hay fever _____ Hives_____
Other:_____
What causes the allergy?_____
Does your child have any food allergies?_____Please explain the symptoms:

_____

_____

Does your child have any chronic illness? Yes No Please explain:

_____

_____

Does your child receive any medication regularly?_____
Is your child on any medication now? Yes No
If yes specify the kind of medication, the reason it is been given, when it is administered and for how long_____

_____

_____

Has your child had any serious accident(s)? If so, please explain:_____

_____

Has your child had any operations? Yes No
If yes, give dates and describe_____

_____

Does your child have any special needs or disibilities that we should be aware of?
Yes No If yes, please explain_____

_____

Do you have concerns in the following areas (if not applicable write N/A)?
Physical_____ Speech_____ Hearing_____
If yes, please explain_____

_____

Developmental History:

Please answer to the best of your remembrance: (If not applicable to your child, write N/A).

Age at which child: Crawled_____ Sat Alone _____ Walked Alone _____

Named simple objects:_____Spoke in sentences_____Slept through the night_____

Began toilet training_____Does child fall easily? Yes No Is child a climber? Yes No

Sleeping Habit:

Has your child shown any problems sleeping: Yes No If yes, please explain:

_____

What time does your child go to bed?_____Awaken:_____

(Please note that all infants will be placed on their back when sleeping in the center.)

Do you have a special way of helping your infant/toddler go to sleep? Yes No

If yes, How?_____

Does your child sleep in his/her own room? Yes No

Does your child sleep alone or in a bed with someone else?_____

Does child walk, talk or cry out in his/her sleep?_____

What does child take to bed with him/her?_____

Child's mood on awakening?_____

Does child take naps at home?_____

Eating/Feeding Habit:

Are there any eating problems? Yes No Please Explain:_____

_____

Are there any dietary restrictions? Explain _____

Does your child have a good appetite and show interest in food? Yes No

What foods does your child dislike?_____

What are your child's favorite foods?_____

Does child eat with a spoon? _____Fork?_____Hands_____

Is the baby: Breast Fed:_____ Bottle Fed:_____Both:_____

If bottle fed with formula, please indicate the type of formula used, any other formula that could be substituted and formulas that should not be given to your child_____

_____

Do you give your child vitamin/mineral preparation regularly? Yes No

If yes, which one?_____

Infant feeding schedule_____

Toilet Habits

Is the child toilet trained?_____Can child indicate his/her bathroom needs?_____

Does child need help encouragement with toileting?_____What word is used for urination?_____

Bowel movement?_____Does the child have accidents?_____Does child wet bed at night?

_____How often?_____Comments:_____

Social Relationships

Has the child had experience in playing with other children?_____

Is child friendly?_____Aggressive?_____Shy?_____

Withdrawn?_____How does child get along with siblings?_____

Adults?_____What age does child prefer to play with?_____

Does child know any other children in the center?_____

Do you feel that child will adjust easily to the center?_____

Does child enjoy being alone?_____Does child relate to strangers?_____

Does child seek a lot of adult attention?_____

What makes child especially angry or upset?_____

_____

How does child show his/her angry feelings?_____

What is the best way to handle these feelings?_____

_____

What is your philosophy of discipline?_____

_____

What frightens your child?_____

What does child like to do at home?_____

What special skills or interests does child seem to show?_____

Home Setting

Child lives with:_____

Are there any special situations in your home in which we should be aware?_____

Has there been any recent family changes about which we should be aware?_____

Communication/Interactions:

What is the primary language spoken at home?_____

Other languages child understands?_____Speaks?_____

How does your child express needs?_____

How does your child cope with separation? _____

What do you find best comforts your child?_____

How does your child respond to other children?_____

Does your child have any special fears that you are aware of?_____

How does your child show stress and what do you do to relieve it?_____

If your child has not been in a group child care setting previously, has your child had group play experiences? For how long and of what nature?_____

Do you have any concerns about your child's development?_____

Religious/Cultural Beliefs & Information:

Are there any other aspects of your child's cultural and or religious background that you would like to share with us?_____

Comments:

In what particular ways can we help your child this year?_____

_____ _____

Parent/Guardian Signature Date