Internal Use Only:

- Health Form
- Dental Form
- Payment

Admitted:_________

Prep *EX!*

DC Prep's Extended Learning Program

Enrollment Application Form

2017-18 School Year

Legal Guardian 1: First	Last	**Best Contact #:** Type: Home / Work / Cell	**Second Phone #:** Type: Home / Work / Cell
Legal Guardian 2: First	Last	**Best Contact #:** Type: Home / Work / Cell	**Second Phone #:** Type: Home / Work / Cell
Relationship to Student:		**Email Address:**	

Please list information below for all students who will attend Prep *EX!*

Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**

Applications will be accepted on a space-available basis.
Completed applications include health forms and payment
Please allow 1 day timeframe for processing

PAYMENT INFORMATION (Choose one)

_____ **Full Price** I pay full price of $180 a month. I will submit my September payment **after August 2nd**

_____ **Subsidy** I will submit a voucher to subsidize some or all of the ***Prep*** *EX!* fees **after August 15th**. I agree to pay any co-pays assigned to me by the Child Care Subsidy Program.

_____ **Sibling Rule** My child at the Middle Campus is enrolled in Prep Hour until 5:00. My child at the elementary campus will participate in ***Prep*** *EX!* free of charge until my middle-schooler is dismissed.

Name of middle-schooler: ________________________ Grade:______________

Students with outstanding Prep *EX!* ***balances from last school year must settle their account before enrolling.***

Payments can be submitted online via our website's link to Paypal or at the Front Desk via cash, check or money order.

Please retain a receipt for your records.

SY 2017-18 *Prep EX*! Pick up

In an effort to ensure your child's safety, please support us in ensuring we have the most accurate pick up lists for your child. Include everyone allowed to pick up your child from aftercare. One must be completed for all children enrolled in aftercare.
If pick up is the same for all children, please indicate that.

Date Updated :_________ _____________ ______________ _______________

Child Name			
Grade:			
Parent 1:		Parent 2:	
Pick up Name	Pick Up Relationship	Phone 1	Phone 2
1.			
2.			
3.			
4.			
5.			
6.			

Child Name			
Grade:			
Parent 1:		Parent 2:	
Pick up Name	Pick Up Relationship	Phone 1	Phone 2
1.			
2.			
3.			
4.			
5.			
6.			

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child ______________________________, born on ____________________, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: ____

Address: ____

or:

Physician: ________________________ M.D. Telephone No: ______________ (Area Code)

Address: ____

I give permission to ____ (Name of Facility or Caretaker), located at

____, 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 Physical Conditions: ______________________________

____

Signature: ______________________ Relationship to Child: ______________

Address: ____

Telephone No: ______________ (Home) ______________ (Business) ______________ (Pager/Cell Phone)

Date: ______________ (Month/Day/Year) Date Updated: ______________ (Month/Day/Year)

810 First Street, NE, 4th floor, Washington, DC 20002
Phone: 202.727.1839 • Fax: 202.727.8166 • www.osse.dc.gov

***Prep** EX!*

DC Prep's Extended Learning Program

2017-18 SCHOOL YEAR HANDBOOK CONFIRMATION FORM

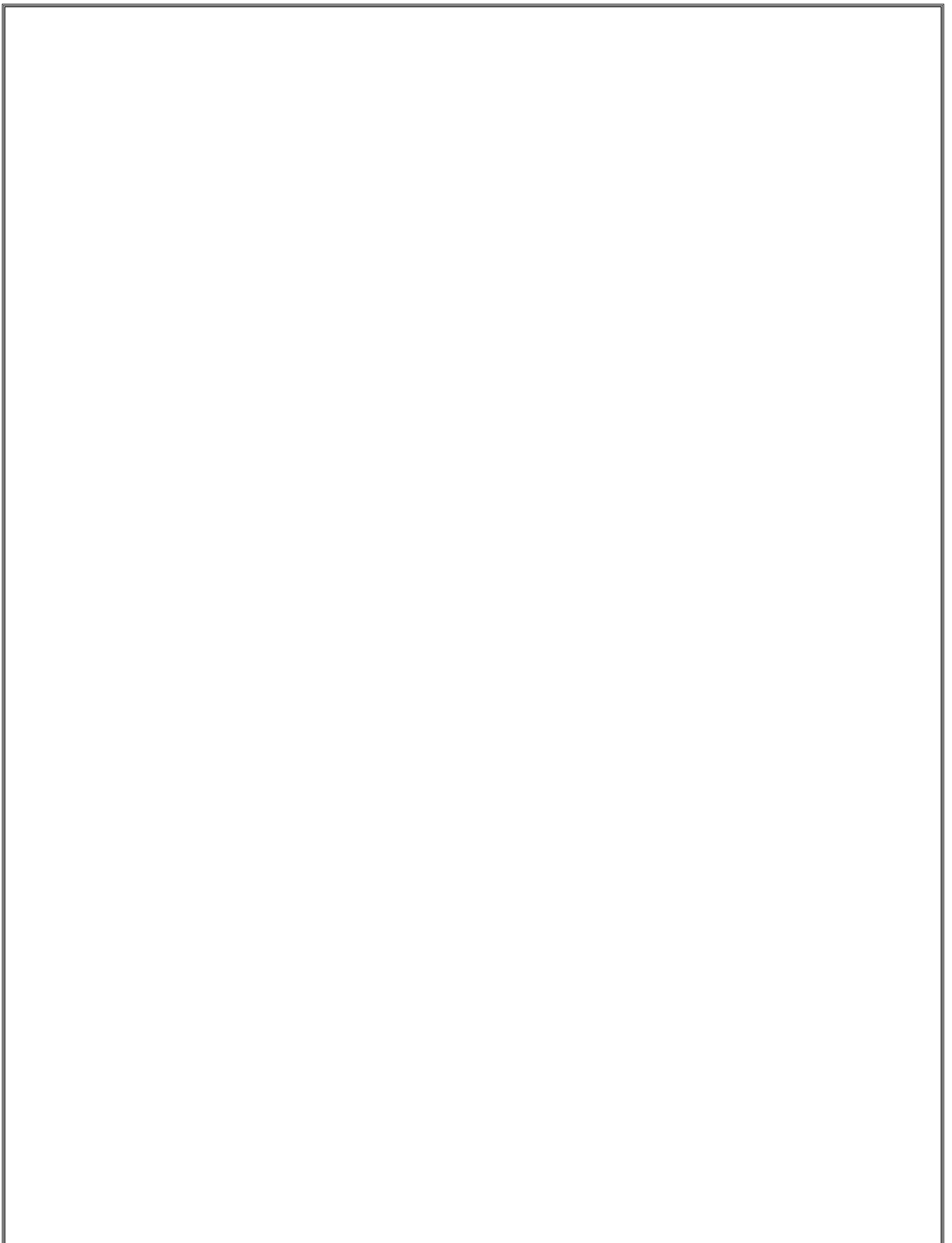
*Please **clearly** print your name and sign the following form, prior to turning it in with your child's campus front desk Operations Assistants,*

I, ____________________________________, have reviewed the 2017-2018 ***Prep** EX!* and agree to the rules and procedures it contains.

Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**
Student Name:	First	Last	**Grade** (2017-18 SY):	**Campus:**

Signature: ___________________________________

Date: _______________________



CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

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):	Dental/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

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 ☐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: ____/____ ☐ NML ☐ABNL	Body Mass Index (BMI)__________ %__________
HGB / HCT (Required for Head Start)	Vision Screening Right 20/____ Left 20/____ ☐ Glasses ☐ Referred		Hearing Screening Pass________ Fail________ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ 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: (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, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

____

____

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

____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's 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 Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** ALL lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: **Fax:** 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO 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 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/NP Signature	Date
Address	Phone	Fax

Part 5: 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, child care, camp, or appropriate DC Government Agency.

Print Name	Signature	Date