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:	War
Emergency on ac ;	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_____

Frunary are rov, er e ,ca :	Denlisl/Dental Provider:	0 e /Ca/ ☐ Private Insurance ☐ None o Other_____

Part 2. Child's Clinical Examination (to be completed by lhc Dcntnl Provl<lcl')

Date of Exam_____

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

Tooth#	Tooth#	Tooth#	Tooth #
1	17	A	re
2	18	B	L
3	19	C	M
4	20	D	N
5	21	E	0
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
II Non-restornblc/ Extraction
1D-One surface decay
UE- Uuernpted T ooth
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
I. Gingival Inflammation	y	N	
2. Plaque and/or Calculus	y	N	
3. Abnonnal Gingival Attachments	y	N	
4. Malocclusion	y	N	
5. Other (e.g. cleft lip/palate)			
Preventive services completed	DYes	D No	

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been amiro»riatelv examined. T,·eatrnent D is complete. D is incomplete. Referred to

LJLJ:S/LJMLJ :signalur e ,--nn, ,vnmo ua,e

AUU!'CSS

t'IJOne rnx

Part 5. Required Parent/Guardian Signatul'es

Parent or Guardian Release of Health Information.

I give permission to /he signing heallh examiner or facilily to share the health information on /his form with my child's school, childcare, camp, or Department of Heal/h

PmFIT"/vi'iFJt:: ol parent or guardian

c,1c,1m tUKt: 01parenr or guaratan uare

Instructions for Completion orOrol Hcnlth Assessment form: District of Columbia Child Health Ccrtificnte

This Form replaces the Dental Appraisal Form used for enh·y into DC Schools, all Head Stal'! programs, Childcare providers, camps, after school programs, sports or athletic pnrticipation, or any other District of Columbia activity requiring a physical examination. The form was develop(ld by the DC Department of Health antl follows the Amcricim Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Ent rance Oral Health Exiuuinations. AAPD recommends that a child be given an oral bcalth 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 Tnsurance Portability and Accountability Act of 1996 (HIPPA) for the hea lth providers, and the Fiunily Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

Gcncrnl Instructions; Please use black ball point pen when completing this form.

Part 1: Child's Personal Tnfonnation
Pleas e complet e all sections including child 's race or ethnici ty. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child lias no dental provider and is uuinsured, 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 Pl'ovlder: Form must be fully completed. The Universal Tooth Numb el'lng System is **used.**
Please use key to document all findings for each tooth. An 'X' ..§ignifies n missing tooth (teeth) with no replacement;
l lnon-restorable/extrnct ion; **UE:** unerupted tooth; S: Sealants;• Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** tliree surface decay; **4D:** more then three surface decay

The Key should be used to designate status for each toot h at time of examination on the Oral Heallh Assessment Form. Ifa portion ofan existing restorationis defective or has recurrent decay, but par! oflhe restoration is inlacl, 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: une rupted, does not apply to n missing primary tooth when a permanent tooth is in a nom1al cn11)tion pattern.

Part 3: Clinical Findings and Recommendation s

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 inflammati on).
1- Gingival inflammation adjace nl lo an erupting tooth is **NOT** noted.
l- lnflammation adjacent to orthodontically banded teeth or a dental appliance - whether fixed or removable is noted.
2- Indicate if ther e 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 tcxh1re for a finding of'NO' lo be recorded.
3- Fremnn attaclnncnts labial, snblingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause ofn specific problem- e.g., spacing of central incisors, speech imp ediment, etc.
4- Stah1s of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class HI, an overbite, over jet, cross-bite 01· end lo end.
5- Other is to be used, toge ther with comments, for conditions such as cleft lip/palate.
Indica te whether oral health preventive sei"vices such as prophylaxis, sealant and or fluoride treatment h11ve been administe red.

Part 4. Final Evaluation/Required Dental Pl'ovldcl' Signatul'c; Indicate wl1ethcr the child has bee n npp roprintc ly examined ,md iftrcatmenl is complete. If trealmenl is incomplete refer patient for follow up care. Dentist must sign, date, and provide required information.

Parts Required Signatures. This Fonn Will Not Re Conmiete Without Pnrent or GmmHan Signature & Pote
The parent or guardian must print, sign, and date this par!. By signing this section the parent or guardian gives permissio n lo the dentist or facility to share the oral health information on this form with the child's school, ch ildcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.

***

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information — ParenUGuardian: *Please complete Part 1 clearly and completely & sign Part 5 below.*

Child's Last Name:	*Ch/Id's First & MIddloName:*	*Date of Birth:* *uenaer:* oM aF	*"ace,,cm/1/Ctry: 0 White Non H1spamc a mac,,vo n r11spamc a Hispanic a Asian or Pacillc Islander a Oilier*
Parent or Guardian Name:	*Telephone:* aHome ace/I aWork	*Home Address:*	*vv,m,:*
Emergency Contact Person:	*Emergency Number.* aHome ace/I aWork	*City/State (iiotherthan D.C.)*	*---z,pcoCfe:*
School or Child Care Facility:	*dcaId a Private Insurance aNone a other*		*Tnmary ,;are Trov1aer (t-CPJ:*

Part 2: Child's Health History, Examination & Recommendatlons — **Health Provider: Form must be fullv completed.**

DATE OF HEALTH EXAM:	WT 0 LBS 0 KG	HT DIN DCM	BP: <" Y"' D NML D ABNL — Body Mass Index,,, Y<>> (BMI) %
HGB/HCT *(Required far H1.uISla_rf)*	Vision Screening Righi 20/ Left20/ — D Glasses D Referred		Hearing Screening Pass Fail D Referred

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	D NO	D YES	D Referred D Under Rx	Language/Speech	D NONE	DYES	D Referred D Under Rx
Seizure	D NO	O YES	D Referred D Under Rx	Q_velopl1wnU- Behavioral	0 NONE	DYES	D Referred D Under Rx
Diabetes	D NO	D YES	D Referred D Under Rx	other	D NONE	DYES	D Referred D Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has Ihe chlld seen a DenlisUDerital Provider within the last year? DYES ONO D Referred

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

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

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
CI NONE CI 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 & Testlna:

TB RISK ASSESSMENTS	D HIGH-) DLOW	Tuberculin Skin Test (TST) DATE:	0 NEGATIVE D POSITIVE	If TST Posllive 0 CXR NEGATIVE OCXRPOSITIVE OTREATEO	Health Provider: POSITIVE TST should be referred lo PCP !or evaluallon. For quaslions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	D YES-) ONO	LEAD TEST DATE:	RESULT:	Heollh Provider: l!illeadlevels must be reported lo DC Childhood Lead Poisoning Ptevenuon Program: Fax: 202-481-3770	

Part 4: Reaulred Provider Certification and Slimature

CI YES IJ NO This child hasbeen 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.

IJ YES IJ NO This athlete Is cleared for competitive sports.

IJ YES IJ NO Age-approp riate health screening requirements performed within current year. If no, please explain:

Pnnt Name | MD/NP Signature | Date

Aaare ss | Phone | Fax

Part 5: Reaulred Parental/Guardian Signatures./Release of Health Information\

I givepennlss/onlo/he signing health examlner llaclllly to share the haatth fnfonnaUon on this tonnv.llh my child's school, lch/ldcare, camp, or appropriate DC Government Agency.

Print Name | Signature | Date

DISTRICT OF COLUMBIA UNIV ERSAL HEALTH CERTIFICATE

Student's Name: _____ / _____ / _____ Date of Birth: _____ / ___ / _____

Last First Middle M o. /Day/ Yr.

Sex: D Male D Female School or Child Care Facility: _____

Section 1: Immunization: Ploase fill In or attach er,ulvelent oo f>v wlt h p r o v id e r s lr,n atur e end d ate.

IMMUNIZATIONS RECORD COMPLETE DATES month dov, vder) OF VACCINE DOSES GIVEN

D i ohthe ri a,Te tanu s, Per tussis (DTP,DTaPl

D T (<7 vrs. l / Td (>7 yrs.l

Tdao Booster

H a em oo h ilus influ en za T ype b f H l b l

Hoea till c B <H oeBl

Polio (IPV, OPVl

Meaass,mos,ubs(MRl

Meaass

Mumos

R ubell a

Va rl ce lla

Chicken Pox DlseasoHistory: Yes D When: Month Year

Verified by: _____ (Health Gare Provider)

Name &Title

Pneurnococcal Conjugate

Heoatltls A fHeoAl (Born on or after 01/01/20051

M enln aococ c alVacci ne

Hum an P aolli om avlru s (HPV)

Influenza (Recommended)

Ro tav iru s (R eco mm ende d)

Other

Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION For Health Care Provider Use Only.

I ce rt i fy that the above student has a valid medical contraindication to being immunized at the lime against: (chockall that apply)

Diphtheria: Ll Tetanus: LJ Pertussis: L) Hlb: LJ HepB: L) Pollo:L) Measles: L) Mumps: L) Rubella: L) Varicella: Ll Pneumococcal: L)

HepA:L) Menlngococcal: LJ HPV: LJ

Reason: _____

This Is a permanent condition (_) or temporary condition L) until ___ /___ /_ _.

Signature of Medical Provider Print Name or Stamp Dale

Section 3: Alternative Proof of Immunity. To Ile comnleted by Health Care Provider or Health Official

I certify that the student named above has laboratory evidence of Immunity: (Check all that apply& attach a copy of tiler resulls)

Diphtheria: L) Tclanus: L) Pertussis L) Hib: L) HepB:L) Pollo: L) Measles: LJ Mumps:L) Rubella:L l Varicella: L) PneumococcalL)

HepA: L) Meningococcal: LJ HPV: LJ

Signature of Medical Provider Print Name or Stamp Date

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

Medication Authorization Form

Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.1; "No Child Development Facility may provide medicine or treatment, with the exception of emergency first aid, to any child, unless the Facility has obtained a written medical order or prescription from the child's licensed health care practitioner and the written consent of the child's parent(s) or guardian."

Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.4; "The Facility shall maintain a medication log, on a form approved by the Director, on which the Facility shall record the date, time of day, medication, medical dosage, method of administration, and the name of the person administering the medication, each time any medication is administered to a child."

Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the
Name of Facility

below noted prescribed medication to my child _____ born on _____

Name of Medication	Time/Frequency	Dosage	Effective Dates	
			From:	
			To:	
			From:	
			To:	

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

Part II: To be completed by the Center Director or designee:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE RETAIN A COPY FOR YOUR FILE

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

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

!' HONE: (202) 727-1839•FAX:(202) 741-5304 MAILING ADDRESS: 810 FffiST ST RF.ET, NE•4fh flLOOIMVAS HINGTON DC 20002

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 aulhorize the following hospital or physician to give the emergency medical treatment required:

Hospital: ____________________

Add ress: ____________________

or:

Physician: _ _ _ _ _ _ _ _ _ _ _ _ M.D. Telephone No: ____________________
(Arcn Code)

Address: ____________________

I give permission to - - - - - - - - - - ---,,=-----=--=---=---c- - - - - - - - - - located at
Nam oCFu:l lily 01 Cruetalcr

_ _, 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 Ins urance Company: ____________________

Name of Policy Holder: _ _ _ _ _ _ _ Relationship to Child: ____________________

Policy Number: _ _ _ _ _ _ _ _ _ _ Coverage: ____________________

Medicaid Number: ____________________ State: D DC D MD D VA

Child's Known Allergies or Physical Conditions: ____________________

____

Sign ature: _ _ _ _ _ _ _ _ _ _ _ _ Relationship to Child: ____________________

Address: ____________________

Telephone No: ____________________ ____________________ ____________________
Jl omo Husine.1s Prigcr/Ctll Phone

Date: ____________________ Date Updated: ____________________
Month/DayNei.r Mo111h/Day/Ye:tr

NOTE: Place on file in child's folder/rcco1·d

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727·1839•FAX: (202) 741·5304 MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ **Sex:** D Male D Female
Lnsl First M.I.

Dale of Birth: Home#: Lang uage Spoken At Home_____

Home Addre ss:
Number s1,cc1 Apl. /1 Stn.to Zll'

Father: _____ Home# _____
Lnsl First M.I. Bu siness # _____

Home Address: _____
Number Strccl Apl. H S tale ZIP

Business Address: _____
Numbtr S1ree1 Apt U St''lo ZIP

Mother: _____ Home# _____
LMI Fi,st 1'll Business# _____

Home Address: _____
Number Strcel Apt.II StOh!: ZIP

B usiness Address: _____
Number St,ccl Apt. H Stote ZIP

Relative or Guardian: _____ Home# _____
Last J.'irst M .L Business# _____

Home Address:
Nuniber s1,u1 Apt. N s 1. 10 ZIP

Business Address: _____
Number Strccl Apt U Stnle ZIP

Person to be contacted in case of an emergency (other than pnrent/gunrdinn):

_____ Relationship to child: _____
LISI Fi1s1 M.L

Address: _____
Number Street /lpl.# Slalo ZIP Phone //

Designated individm,I nuthorized to receive child at end of session:

_____
Last First M.I.

_____
LMI First M.I.

_____
Last First M .L

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Relationship to child: _ _ _ _ _ _ _ _ Date: _____

TO BE COMPLETED Bl' THE FACILITY

Date of Admission: _ _ _ _ _ _ _ _ _ _

Date of Withdrnwnl: _ _ _ _ _ Reason: _

Health and Dental Authorization Release Form

2017-2018

I, _____, parent/guardian of

_____ release the authorization

of the District of Columbia Oral Health (Dental Provider) Assessment

Form and the District of Columbia Universal Health Certificate form to

Springboard Education in America.

Student Name (print):_____

Parent Name (print):_____

Parent signature: _____

Date:_____

PARENT ACKNOWLEDGMENT FORM

By signing this form, you are acknowledging that you have read, understand and are willing to adhere to the policies listed within the Family and Health Handbook and the Program/Policy Statement.

Site Coordinator's Signature_____

Parent/Guardian's Signature_____

Date:_____

Springboard Education in America, LLC
420 Bedford Street, Suite 210
Lexington, MA 02420

Springboard Authorizations Form 2017-2018

Enrollment Information: I have read and understand the enrollment information on admission and tuition. Initial _____

Updated Child's Records: I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status and immunization records, etc. Initial _____

Hospital Transportation: In case of medical emergency I give permission for Springboard to release my child and to be transported to a hospital. My preferred hospital is:
(Name of Hospital) _____

(Hospital Address) _____

(Hospital Phone Number) (_____)_____ or to the nearest hospital by ambulance subject to the EMT's authority once child has been released to their care. Initial _____

First Aid/CPR: I give permission for Springboard staff to administer First Aid & CPR to my child, if necessary. Initial _____

In the event of an emergency: I give Springboard permission to act on my behalf and provide needed medication and assistance. Initial _____

Video/Picture Permission Slip: I give permission and consent for Springboard to take pictures/video of my child during program hours and activities. I further give permission and consent that any such photographs/video may be published and used by Springboard Education in America and its agents, to illustrate and promote the Springboard experience on Springboard's website, social media, or for the purpose of brochures and advertisements. Initial ___

Release of Records: I authorize Springboard to access and review all health and educational records on file with my child's school, for the purposes of providing a safe, healthy environment that supports my child's academic growth and achievement. This data may include, but is not limited to, an IEP, disability evaluations and test data. Springboard adheres to the highest levels of confidentiality when accessing information contained in these records. Initial _____

Medications: I understand that in order for my child to be given medications (prescriptions and/or over the counter medications), I must provide written authorization by the physician and parent. Medication must be provided in the original bottle with an original label. Initial _____

Sunscreen: I give permission for Springboard to apply sunscreen to my child if assistance is needed. I will supply the sunscreen in its original bottle to you clearly labeled with my child's name. Initial _____

TV/Video: I give permission for my child to use or view TV and or video games during their time at Springboard. I understand that the site coordinator monitors all TV exposure and videos. Initial _____

Parent Agreement: The child named on this form is "awesome," but I understand that children who behave in a "not-so-awesome" way can get sent home from their program without a refund. Initial _____

I have read and initialed the above Authorizations and Policies

Parent Signature _____ Date _____

Print Parent Name _____

Print Child Name_____

All students must have a completed form on file in order to attend the Springboard Program. Please return your completed form to the Springboard Program at your child's school.

6/2/17