

# DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary			
Home Address:		Apt:	City:	State:	ZIP:	
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer						
Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer						
Parent First Name:		Parent Last Name:		Parent Phone:		
Emergency Contact Name:			Emergency Contact Phone:			
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None		Insurance Name/ID #:				
Has the child seen a dentist/dental provider within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ / _____ <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight: _____ <input type="checkbox"/> LB <input type="checkbox"/> KG	Height: _____ <input type="checkbox"/> IN <input type="checkbox"/> CM	BMI: _____	BMI Percentile: _____
Vision Screening: Left eye: 20/_____ Right eye: 20/_____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected		<input type="checkbox"/> Wears glasses <input type="checkbox"/> Referred <input type="checkbox"/> Not tested				
Hearing Screening: (check all that apply) <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested <input type="checkbox"/> Uses Device <input type="checkbox"/> Referred						
Does the child have any of the following health concerns? (check all that apply and provide details below)						
<input type="checkbox"/> Asthma	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Sickle Cell				
<input type="checkbox"/> Autism	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care. Details provided below.				
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements. Details provided below.				
<input type="checkbox"/> Cancer	<input type="checkbox"/> Language/Speech	<input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions. Details provided below.				
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other: _____				
<input type="checkbox"/> Development	<input type="checkbox"/> Scoliosis					
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures					
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?		Skin Test Date:		Quantiferon Test Date:		
<input type="checkbox"/> High → complete skin test and/or Quantiferon test		Skin Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative <input type="checkbox"/> Positive, CXR Positive <input type="checkbox"/> Positive, Treated				
<input type="checkbox"/> Low		Quantiferon Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive		<input type="checkbox"/> 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 <i>Every child must have 2 lead tests by age 2</i>	1 <sup>st</sup> Test Date:	1 <sup>st</sup> Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1 <sup>st</sup> Serum/Finger Stick Lead Level:			
	2 <sup>nd</sup> Test Date:	2 <sup>nd</sup> Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	2 <sup>nd</sup> Serum/Finger Stick Lead Level:			
HGB/HCT Test Date:			HGB/HCT Result:			

**Part 3: Immunization Information** | To be completed by licensed health care provider.

Immunizations	Provide in the boxes below 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):				
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				

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

**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**. Additional clearance(s) needed from:  N/A  No  Yes  Yes, pending additional clearance

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

<b>Licensed Health Care Provider Office Stamp</b>	<b>Provider Name:</b>
	<b>Provider Phone:</b>
	<b>Provider Signature:</b>
	<b>Date:</b>

Access health insurance programs at <https://dchealthlink.com>. You may contact the Health Suite Personnel through the main office at your child's school.

**OFFICE USE ONLY** | Universal Health Certificate received by School Official and Health Suite Personnel.

<b>School Official Name:</b>	<b>Signature:</b>	<b>Date:</b>
<b>Health Suite Personnel Name:</b>	<b>Signature:</b>	<b>Date:</b>

**Oral Health Assessment Form**

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

**Instructions**

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

**Part 1: Student Information (To be completed by parent/guardian)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

School or Child Care Facility Name \_\_\_\_\_

Date of Birth (MMDDYYYY)

--	--	--	--	--	--	--	--

Home Zip Code

--	--	--	--	--	--

School Grade	Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2: Student's Oral Health Status (To be completed by the dental provider)**

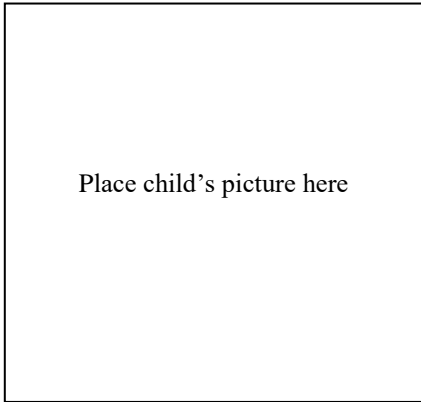
	Yes	No		
Q1 Does the patient have at least one tooth with <b>apparent cavitation</b> (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	<input type="checkbox"/>	<input type="checkbox"/>		
Q2 Does the patient have at least one <b>treated carious tooth</b> ? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a <b>partially or fully retained sealant</b> ?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring <b>care before his/her routine check-up? (Early care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have <b>pain, abscess, or swelling? (Urgent care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q6 How many <b>primary teeth</b> in the patient's mouth are affected by caries that are either <b>untreated or treated with fillings/crowns</b> ?	Total Number			
	<input type="text"/> <input type="text"/>			
Q7 How many <b>permanent teeth</b> in the patient's mouth are affected by caries that are either <b>untreated, treated with fillings/crowns, or extracted due to caries</b> ?	Total Number			
	<input type="text"/> <input type="text"/>			
Q8 What type of dental insurance does the patient have?	Medicaid	Private Insurance	Other	None
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 child care 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.

# ALLERGY ACTION PLAN

\*Must be accompanied by a Medication Authorization Form



**CHILD'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

**Asthmatic:** No \_\_\_\_\_ Yes \_\_\_\_\_ (high risk for severe reaction)

SYMPTOMS:	Give this Medication	
<i>The child has ingested a food or allergen or exposed to an allergy trigger:</i>	Epinephrine	Antihistamine
But is <b>not</b> exhibiting or complaining of any symptoms		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Throat:</b> * difficulty swallowing (choking feeling"), hoarseness, hacking cough		
<b>Lung:</b> * shortness of breath, repetitive coughing, wheezing		
<b>Heart:</b> * Weak or fast pulse, low blood pressure, fainting /"passing out", pale, blueness		
<b>Other:</b>		

The severity of symptoms can quickly change. \*All above symptoms can potentially progress to a life-threatening situation.

Medication:	Dose:	
Epinephrine		
Antihistamine		
Other		

**\*ACTION FOR ALLERGIC REACTION\***

- If ingestion is suspected and/or symptoms are: \_\_\_\_\_, give \_\_\_\_\_ IMMEDIATELY!
- **CALL 911.** Tell them what medications you have already administered. **DO NOT HESITATE TO CALL 911!**
- Call Parent 1: \_\_\_\_\_ phone: \_\_\_\_\_, Parent 2 \_\_\_\_\_ phone: \_\_\_\_\_, or emergency contacts: \_\_\_\_\_ phone \_\_\_\_\_ OR \_\_\_\_\_ phone \_\_\_\_\_
- Call Dr. \_\_\_\_\_ phone: \_\_\_\_\_

\_\_\_\_\_  
 Parent's Signature Date

# Allergy Action Plan (Continued)

**Must be accompanied by a Medication Authorization Form**



**CHILD'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

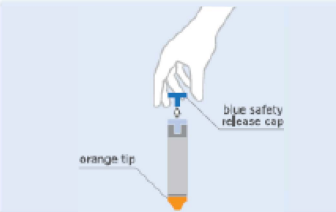
**ALLERGY TO:** \_\_\_\_\_

Is the child Asthmatic?       No       Yes (If Yes = Higher Risk for Severe Reaction)

**The Child Care Facility will:**

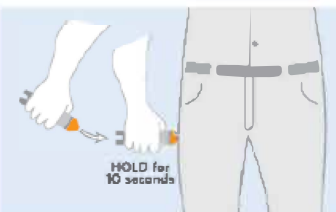
- Reduce exposure to allergen(s) by: (no sharing food, \_\_\_\_\_)
- Ensure proper hand washing procedures are followed. \_\_\_\_\_
- Observe and monitor child for any signs of allergic reaction(s). \_\_\_\_\_
- Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) \_\_\_\_\_
- Ensure that a person trained in Medication Administration accompanies child on any off-site activity. \_\_\_\_\_
- \_\_\_\_\_

EPIPEN®
(Epinephrine) Auto-Injectors 0.1/0.15mg
userguide



1

**Pull off the blue safety release cap.**



2

**Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.**

**Please note:** As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine, which you inject into your outer thigh. DO NOT INJECT INTRAVENOUSLY. DO NOT INJECT INTO YOUR BUTTOCK, as this may not be effective for a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.

Call 911

3

**Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.**

**To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit [epipen.com](http://epipen.com).**

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 EpiPen®, EpiPen 2-Step®, and EpiPen Jr. 2-Step® are registered trademarks of Mylan Inc. and each belong to its wholly-owned subsidiary, Day Pharma, L.P.

**The Parent/Guardian will:**

- Ensure the child care facility has a sufficient supply of emergency medication. \_\_\_\_\_
- Replace medication prior to the expiration date \_\_\_\_\_
- Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed. \_\_\_\_\_
- \_\_\_\_\_



## Medication Authorization Form

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1; "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."*

*Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5, "A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log."*

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

I do hereby give permission to \_\_\_\_\_ to administer the following  
*Name of Facility*

prescribed medication to my child \_\_\_\_\_ born on \_\_\_\_\_.

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

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### **Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:**

Name of Medication	Date	Time Given	Reactions	Staff Initials

**PLEASE PLACE A COPY IN THE CHILD'S FILE.**



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# EDUCATION

## REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

**Child:** \_\_\_\_\_ Sex:  Male  Female  
Last First M.I.  
 Date of Birth: \_\_\_\_\_ Home #: \_\_\_\_\_ Language Spoken At Home \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Parent:** \_\_\_\_\_ Home # \_\_\_\_\_  
Last First M.I. Business # \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
Number Street Apt. # State ZIP  
 Business Address: \_\_\_\_\_  
Number Street Apt. # State ZIP

**Parent:** \_\_\_\_\_ 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 (other than parent/guardian):**  
 \_\_\_\_\_ 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:** \_\_\_\_\_



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***DIVISION OF EARLY LEARNING  
Licensing and Compliance Unit***

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT  
(Update Annually)**

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 \_\_\_\_\_, located at  
Name of Facility or Caregiver  
\_\_\_\_\_, 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: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_  
Home Business Cell Phone

Date: \_\_\_\_\_  
Month/Day/Year

Date Updated: \_\_\_\_\_  
Month/Day/Year

**Place in child's folder/record.**





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# EDUCATION

## TRAVEL AND ACTIVITY AUTHORIZATION

- Special one time permission for this activity only       Blanket permission for all given activities

I, \_\_\_\_\_ parent/guardian of  
Name of Parent/Guardian

\_\_\_\_\_ give my permission  
Name of Child

\_\_\_\_\_ for my child to  
participate in the following activities:

### **Trips in the van/automobile** (facility or parent - owned)

\_\_\_\_\_ Explain planned activity - where and when

### **Field trips away from the facility**

\_\_\_\_\_ Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devices and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

- I will allow my child to play outside the fenced area; or  
 I will not allow my child to play outside the fenced area.

This authorization is valid from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

**PLEASE KEEP A COPY IN THE CHILD'S FILE.**

# CCBC Children's Center

5671 Western Avenue, NW • Washington, DC 20015 • Telephone 202-966-3299 • Fax 202-966-1717 • www.ccbcchildrenscenter.org

## CCBC Child & Family Form

Child's first, middle and last name: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ What name should be used at school? \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation and Employer: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation and Employer: \_\_\_\_\_

Emergency contacts:

*We will contact listed individuals in case of an emergency if the parents/guardians cannot be reached. We recommend listing individuals who can be reliably contacted and with whom your child is familiar.*

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Would you be interested in volunteering for/participating in the following events/roles?:

- Annual Auction Committee
- Book Fair
- Open Houses/School Tours
- Room Parent (assists in organizing classroom events and classroom communication)
- Special Event Volunteer (ie. Truck Day)
- Member of the Board of Directors

The information shared below helps us to better partner with you in the care and education of your child as well as understand your child's personality, needs, and preferences. Responses will help us best serve your child and family on this exciting step in their development!

**Does your child have any allergies, medical concerns/conditions, or developmental supports of which we should be aware?** *Additional information regarding allergy action plans will be filled out on a separate form.*

**Who lives with your child? Please list names and ages of siblings if applicable.**

**Please tell us about other adults that care for your child (for example grandparents, other family members, or caregivers/nannies). List names, relationship to child, and how your child refers to them.**

**Is your child toilet trained?** \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ In Progress

**What languages are spoken in your home and by whom?**

**What are some of your favorite family traditions/holidays your family celebrates?**

**What activities, toys, or games does your child particularly enjoy when:**

Playing independently?

Playing with adults?

When playing with other children or siblings?

**What helps calm or soothe your child?**

**Has your child had any classes or school experiences prior to starting school this year?**

**Have there been any recent or upcoming changes in your child's routine or home environment (ie moving, a new sibling, recent extended travel, etc.)?**

**What are the most important things to know about your child?**

# CCBC Children's Center

5671 Western Avenue, NW · Washington, DC 20015 · Telephone 202-966-3299 · Fax 202-966-1717

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CCBC Summer Camp includes water play every day to include (sprinklers and baby pools) during their outdoor time.

## ALLERGY AND SUNSCREEN

Child's Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

Has your child ever been stung by a bee? \_\_\_\_\_

Is there a history of allergic reaction to bee sting in your family? \_\_\_\_\_

\_\_\_\_\_

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I give CCBC summer staff permission to apply sunscreen to my child.

Child's Name \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please make sure your child's name is on the bottle of sunscreen.**

# CCBC Children's Center

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## DISMISSAL AUTHORIZATION

Please list all individuals who may pick up your child regularly. These are people our staff can expect to see frequently upon dismissal. Parents, child care providers, siblings over 16 years of age, relatives, neighbors or car pool participants might be listed here. **It is important to note that if your child's regular dismissal plans have changed, YOU MUST NOTIFY CCBC PERSONNEL IN WRITING OR BY PHONE EVEN IF THE INDIVIDUALS ARE LISTED HERE.** This policy is for the protection of your family.

Child's Name: \_\_\_\_\_ Class: \_\_\_\_\_

Name #1: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

Name #2: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

Name #3: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

### NOTICE:

**If your child must be dismissed to someone other than the people listed on this form, you must inform school personnel in advance, either by phone or in writing. Each individual to whom your child is released must be at least 16 years old. CCBC staff will check identification to ensure that it matches information on this form or information you have supplied. Request to prohibit specific individuals from having access to your child must be brought to the Director's attention.**

\_\_\_\_\_  
Parent's Signature and Date

# CCBC Children's Center

5671 Western Avenue, NW • Washington, DC 20015 • Telephone 202-966-3299 • Fax 202-966-1717

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## PHOTOGRAPH PERMISSION FORM

Please mark one of the following:

- I give*** permission
- I do not give*** permission

for Chevy Chase Bethesda Community Children's Center to use photographs of my child,

\_\_\_\_\_, in the Center's publications and its web site.

In consideration of the opportunity for my child to appear in CCBC Children's Center publications and its website, I hereby release, indemnify, defend and hold harmless CCBC Children's Center from any and all claims that may arise because of such appearance.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_



# Home Visits

CCBC invites you to participate in a home visit! During a home visit, your child's teachers will come to your home to meet your child in a familiar environment, providing everyone an opportunity to connect before beginning school. Meeting teachers at home may make the transition to school more comfortable since they will have already been introduced to the adults in the room. Home visits last approximately 15-20 minutes and are informal.

If you would like to schedule a visit, please fill out the form below and return it with your other registration materials. You will be contacted you in late August to schedule a visit.

Thank you,

Emma Hatton  
Director

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Child's name \_\_\_\_\_  
First Middle Last

Name to be used in school \_\_\_\_\_

Parent 1 Name \_\_\_\_\_ Parent 2 Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent 1 Cell \_\_\_\_\_

Parent 2 Cell \_\_\_\_\_

Please use the back or attach directions to your house and parking suggestions.