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Summer Camp Forms 2018-2019 – DC

Required Forms

- District of Columbia Universal Health Certificate
- District of Columbia Oral Health Assessment Form
- District of Columbia Registration Record for Child Receiving Care Away From Home
- District of Columbia Authorization for Emergency Medical Treatment
- District of Columbia Travel and Activity Authorization
- Wonders General Authorization & Release Form
- Wonders Household Demographic Form
- Wonders Dismissal Authorization Form
- Wonders Emergency Medical Treatment Form
- Wonders Family Custody Form

Forms to be completed as needed

- District of Columbia Medication Authorization Form
- Wonders Babysitting Release Form

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: (>3 yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT ***(Required for Head Start)***	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		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**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:_____/_____/_____
Last First Middle Mo. /Day/ Yr.

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

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
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	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

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

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed 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 titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp 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):	*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*

<u>Instructions For Completion of Oral Health Assessment Form</u>: 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.

<u>General Instructions:</u> 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 s**ign, date, and provide required information.**

Part 5 Required Signatures. <u>This Form Will Not Be Complete Without Parent or Guardian Signature & Date</u>
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.

C&RCFD 045 REV 07/04

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

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

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 _____, 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 Physical Conditions: _____

_____

Signature: _____ Relationship to Child: _____

Address: _____

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

Date: _____ Month/Day/Year Date Updated: _____ Month/Day/Year

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

☐ Special 1-time permission for this activity only ☐ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____give my permission to
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 devises 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 is to 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

NOTE: Place on file in child's folder/record

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

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General Authorization & Release Form

Child's Name: _____

PHOTOGRAPHS: I authorize Wonders to photograph and/or record audio and video of my child while he/she is participating in Wonders programs and activities. I further authorize Wonders to print, publish or otherwise disseminate such photograph(s) and/or audio and video of my child via printed materials, classroom or other Wonders on-site displays, any website operated or maintained by Wonders (e.g., www.wonderslearning.org), or by other means. I understand that such dissemination shall be for the purpose of furthering the educational and/or to promote Wonders.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

FIELD TRIPS: I authorize my child to participate in the Wonders field trip program. I understand that my child may be transported in Wonders activity buses, parent vehicles, school buses, public transportation, or other vehicles, or may walk, depending on the circumstances of the specific trip. I understand that all field trips and corresponding transportation will be supervised by Wonders staff. I understand that this authorization shall apply to all field trips.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

APPLICATION OF SKIN PROTECTION: To protect our children from the sun, we ask that you apply sunscreen on your child each morning before they arrive at school. In the event that you forget to apply it before coming to school we ask that you apply it to your child before you leave the center. Wonders staff will re-apply sunscreen before afternoon outdoor/playground time. For ECE Programs, NAEYC authorizes application of sunscreen only once daily. To avoid any concerns related to possible allergies, individual sunscreens with UVB and UVA protection of SPF 15 or higher must be sent from home, labeled with your child's name to be safely stored at Wonders. I authorize the staff of Wonders to apply non-prescription skin protection (sunscreen, skin lotion or lip balms) on my child as needed
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

APPLICATION OF INSECT REPELLENT: To protect our children from insects, Wonders staff will apply insect repellent before children go outdoors. For ECE Programs, NAEYC authorizes application of insect repellent once a day and requires that only repellent containing DEET be used. We are not allowed to apply any herbal or Homeopathic insect repellent. To avoid any concerns related to possible allergies, individual insect repellents must be sent from home, labeled with your child's name to be safely stored at Wonders. I authorize Wonders to apply non-prescription insect repellent once daily.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

For ECE Programs ONLY
TOOTH BRUSHING: NAEYC requires that all childcare settings provide tooth brushing opportunities to all children who are offered two or meals per day while in our care. Children will brush their teeth with direct supervision of their teachers using toothpaste with fluoride as approved by the American Dental Association. Parents will provide a new, individually labeled toothbrush every three months. Parents will also provide a new toothbrush if the child contracts any contagious illness. I authorize Wonders to offer the opportunity for my child to brush his/her teeth on a daily basis.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

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HOUSEHOLD DEMOGRAPHIC FORM

Child's Name: _____

The following information is requested so we may get to know and understand your child and family. All demographic information on this form is confidential and will be available only to the Director and Wonders Administrators. Consolidated demographic data from this form may be used to seek grants and to inform marketing and fundraising efforts. **This information will not be used in any way to determine eligibility in placement of your child in our programs.**

Child's Date of Birth: _____ Place of Birth: _____
Nickname(s): _____
Is your child adopted? [ ] Yes [ ] No [ ] Domestic adoption [ ] Foreign adoption
Does he/she know? [ ] Yes [ ] No Age of child at time of adoption_ _____
How is adoption discussed at home? _____
_____
How long have you lived in the D.C. area? _____
Language(s) spoken at home: _____
Child's primary language: _____
Other languages spoken by child: _____
Family Religion(s): _____

Household members - List members of the household(s) where the child lives and place a (*) beside those who have a significant role in caring for your child.

Name (as used by child)	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you participate in any religious or cultural observance that might restrict your child's diet at the Center? _____
Date(s) of observance(s) this year: _____
Please list any dietary restrictions during this time_____
How can we support your child during these observations? _____
What are your child's favorite books? _____
What are your child's favorite activities? _____
Does your child have an IEP or a 504 Plan? [ ] Yes [ ] No If yes, please attach
List any developmental, speech, language, hearing, sight or physical and therapy/treatment plans
_____
_____
Is there anything else you would like us to know to better care for your child _____
_____

Family Ethnic Background

	Child	**Parent/ Guardian 1**	**Parent/ Guardian 2**
Asian/Pacific Islander	[ ]	[ ]	[ ]
American Indian/Alaskan Native	[ ]	[ ]	[ ]

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Black	[ ]	[ ]	[ ]
Hispanic	[ ]	[ ]	[ ]
Multiracial	[ ]	[ ]	[ ]
White	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]

Parent/Guardian 1 **Place of birth:** _____

[ ] Mother [ ] Father [ ] Stepmother [ ] Stepfather [ ] Other: _____
[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Age		**Degree(s) received**	**Institution**
[ ] 20-25	[ ] 41-45	[ ] B.A./B.S.	_____
[ ] 26-30	[ ] 46-50	[ ] M.A./M.S.	_____
[ ] 31-35	[ ] 50 or over	[ ] Ph.D.	_____
[ ] 36-40		[ ] J.D.	_____
		[ ] M.D.	_____
		[ ] Other: _____	_____

Place of work: _____ [ ] Full time [ ] Part time
Occupation: _____ Job title: _____
Does your employer have a matching gift program for charitable donations?
[ ] Yes [ ] No [ ] I don't know

Parent/Guardian 2 **Place of birth:** _____

[ ] Mother [ ] Father [ ] Stepmother [ ] Stepfather [ ] Other: _____
[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Age		**Degree(s) received**	**Institution**
[ ] 20-25	[ ] 41-45	[ ] B.A./B.S.	_____
[ ] 26-30	[ ] 46-50	[ ] M.A./M.S.	_____
[ ] 31-35	[ ] 50 or over	[ ] Ph.D.	_____
[ ] 36-40		[ ] J.D.	_____
		[ ] M.D.	_____
		[ ] Other: _____	_____

Place of work: _____ [ ] Full time [ ] Part time
Occupation: _____ Job title: _____
Does your employer have a matching gift program for charitable donations?
[ ] Yes [ ] No [ ] I don't know

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE AND I AGREE TO NOTIFY THE CENTER IF THERE ARE ANY CHANGES.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

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DISMISSAL AUTHORIZATION FORM – DC PROGRAMS

Child Name(s): _____

I, the parent/guardian hereby authorize Wonders Early Learning + Extended Day ("Wonders") to release said Child(ren) from Wonders in accordance with the following (check all that apply):

☐ In addition to Child(ren)' parents and/or guardians, Child(ren) may be released from Wonders to the following person(s) over the age of 16:

Name	Relationship to Student	Phone Number(s)

☐ Student may be released from Wonders on his/her own to walk; or ride a bike; or take public transportation on the following days/times:

By signing this authorization form, I hereby understand that this authorization form will remain in effect unless and until a subsequent authorization form is completed, signed, and received by Wonders or a written revocation of this authorization form is received by Wonders, whichever occurs first. I further understand that Wonders reserves the right to request photographic identification for any or all persons who may attempt to pick-up Child(ren) from Wonders and to refuse to release Child(ren) in accordance with either this authorization form, lawful and enforceable court orders, state or federal laws or, in Wonders sole discretion, for the health and safety of the student.

I, on behalf of myself, my spouse, Student's parent(s), and any and all heirs, assigns, agents, personal representatives, insurers, and any other individuals or entities who could act on my behalf or interests, hereby release and forever discharge Wonders, its officers, directors, agents, employees, assigns, representatives, insurers, volunteers, and any other affiliated individuals or entities, from any and all claims, demands, actions and causes of actions and all liability, whatsoever, whether or not negligently caused, in any manner arising out of Wonders' release of Child(ren) in accordance with this authorization form.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

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EMERGENCY MEDICAL TREATMENT CONSENT FORM

Child's Name: _____

In the event that I cannot be reached, I authorize Wonders to transport my child to the nearest hospital emergency room, at the discretion of the emergency team, and I hereby grant my consent for the hospital and its medical staff to provide my child with any emergency medical treatment which a physician deems necessary. If my child is participating in an off campus activity, he or she will be transported to and cared for at the nearest hospital. I agree to accept all financial responsibility for all medical expenses incurred.

CHILD'S BIRTH DATE: _____CHILD'S CURRENT WEIGHT:_____

List all known special conditions or allergies

Describe all past serious illnesses or hospitalizations and their dates

List all medications currently being taken by child

Health Insurance:/ Name of Policy Holder: _____

Insurance company_____

Employer name: _____

ID #: _____Group #: _____

I hereby certify that the information supplied above is, to the best of my knowledge, complete and accurate.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

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FAMILY CUSTODY FORM

The following information is requested so we are better able to serve your family's needs. The information provided will be held in the strictest of confidence and will only be viewed by authorized employees. Please be sure the information is complete and accurate and update the center of all new custody developments or changes.

Child's Name: _____

CUSTODY INFORMATION

Are Parents Divorced?	[ ] Yes	[ ] No
Are Parents Separated?	[ ] Yes	[ ] No
Is Custody Currently Being Disputed?	[ ] Yes	[ ] No
Has Custody Been Determined By Court?	[ ] Yes	[ ] No
Is Custody	[ ] Joint	[ ] Sole:
		Custody Granted to: _____

If Joint Custody, please describe day to day details of the arrangements.

Please Describe Any Special Circumstances:

Copies of ALL court orders or agreements concerning Custody must be submitted with this form. If there are restrictions on parent contact, a copy of the court order that outlines the provisions of such a decree must be on file at Wonders Early Learning + Extended Day.

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE AND I AGREE TO NOTIFY THE CENTER IF THERE ARE ANY CHANGES.

_____ _____

Parent Signature Date

_____ _____

Parent Signature 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 (s)."
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, medication 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

wonders
early learning + extended day

BABYSITTING RELEASE

I/We, _____, the parents and/or legal guardians of _____, _____, _____(collectively, "the Family") hereby acknowledge and agree as follows:

1. We have read and understand the statement in Wonders' handbook regarding babysitting by Wonders staff.
2. Wonders does not encourage, support or approve the practice of families engaging any Wonders employee or contractor to provide babysitting services, transportation services, or any other service.
3. In the event that the Family does engage any Wonders employee or contractor for any purpose, Wonders does not, in any way, warrant or guarantee the suitability of that employee or contractor for babysitting or any other purpose. Wonders shall not be responsible in any way for any dispute of any nature which may arise between the Family and the employee or contractor, including any and all claims for injury or damage to or loss of property.
4. While engaged by the Family for any purpose, the Wonders employee or contractor is acting outside the scope of his or her employment with Wonders and is an independent contractor of the Family, not a Wonders employee or agent. Any activities or occurrences which occur during such services, including, but not limited to, transportation of children to or from any premises operated by Wonders, are likewise outside the scope of any employment by Wonders. The parents, for themselves and their minor child or children, hereby release Wonders Early Learning + Extended Day and its employees from and hold it harmless and indemnify it against any and all claims arising from the private provision of services.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date