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Enrollment Forms 2020-2021 – DC School Age

Programs 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

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:** ❑ Male ❑ Female ❑ Non-Binary	

Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**

Ethnicity: *(check all that apply)* ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer

Race: *(check all that apply)* ❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer

Parent First Name:	**Parent Last Name:**	**Parent Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	

Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ 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:** ____/____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Development
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney Failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:**_____

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?

❑ High → *complete skin test and/or Quantiferon test*

❑ Low

Skin Test Date: **Quantiferon Test Date:**

Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated

Quantiferon Results: ❑ Negative ❑ Positive ❑ 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 *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**2nd 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.

Licensed Health Care Provider Office Stamp	**Provider Name:**
	Provider Phone:
	Provider Signature:
	Date:

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.

School Official Name:	**Signature:**	**Date:**
Health Suite Personnel Name:	**Signature:**	**Date:**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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	Pre-K3	Pre-K4	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 **apparent cavitation** (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).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many of **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many of **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

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.

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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:** _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

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

Place in child's folder/record.

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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 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 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.

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General Authorization & Release Form

Child's Name: _____

PHOTOGRAPHS – Social Media/Promotion: 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 any website or social media forum operated or maintained by Wonders (e.g., www.wonderslearning.org, Facebook, Twitter, Instagram, etc.), 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

PHOTOGRAPHS – Newsletter/Wonders Communication: 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, Wonders program newsletter, classroom newsletter and/or center newsletter. 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 (Pre-K students only): 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

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General Authorization & Release Form

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)

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

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
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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:	

_____ _____
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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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