



Washington DCJCC Preschool

EMERGENCY INFORMATION

First Child's Name: _____ Second Child's Name: _____

Name of Parent(s) or Guardian(s): _____

Home Address: _____

City, State ZIP _____

Employer(s): _____

Business Address: _____

City, State ZIP _____

Home Phone: _____ Work Phone: _____

Cell Phone(s): _____

(Check box - - for the first number to try in case of an emergency.)

Email Address(es): _____

Please provide an email which you check often. We will be sending out regular notices with updates and important information throughout the year.

Known Allergies and/or Food Restrictions: _____

Please give detailed information on the Health form

Please list up to three people, other than the parent/guardian(s), who are 1) a good alternate contact in case of emergency, and 2) authorized to pick your child(ren) up from school.

1.) Name: _____

Relationship to Child(ren): _____

Home Phone: _____

Work Phone(s): _____

Cell Phone(s): _____

Email Address(es): _____

2.) Name: _____

Relationship to Child(ren): _____

Home Phone: _____

Work Phone(s): _____

Cell Phone(s): _____

Email Address(es): _____

3.) Name: _____

Relationship to Child(ren): _____

Home Phone: _____

Work Phone(s): _____

Cell Phone(s): _____

Email Address(es): _____

I hereby give permission for the above named individuals to pick up my child(ren) from school.

Signature _____

Printed Name _____ Date _____

The following individuals are NOT authorized to pick up my child(ren) from school:



Washington DCJCC Preschools

1529 Sixteenth Street NW, Washington, DC 20036

t. (202) 518-9400

f. (202) 518-9420

www.washingtondcjjc.org

PERMISSION TO TAKE OFF PRESCHOOL GROUNDS

We are asking you to sign this form below, which gives permission for your child to join all activities away from the preschool building.

I understand that the Washington District of Columbia Jewish Community Center will provide supervision on all trips taken with my child's group during the program and that the District of Columbia Jewish Community Center will make every reasonable effort to ensure the safety of all participants.

I am also aware that the Washington District of Columbia Jewish Community Center cannot assume any responsibility for any accident going to, from or during the trip. I, therefore, release the District of Columbia Jewish Community Center and its agents, servants, and employees of any liability of any injuries or illness to my child.

I give permission to the District of Columbia Jewish Community Center staff members supervising the trip to acquire medical attention at my expense for my child if need arises.

Participant's Name

Parent or Guardian's Signature

Date



PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, date of birth _____, month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ Telephone No: _____
M.D./N.P. (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 Health Conditions: Yes No
(If yes, explain here: _____

Home Address: _____
Street City/State Zip Code

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

Signature: _____

Relationship to Child: _____

Date: _____
month/day/year



DISTRICT OF COLUMBIA CHILD HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 6 below.

Form for Part 1: Child's Personal Information, including fields for Child's Last Name, Parent or Guardian Name, Emergency Contact, School or child care facility, and Insurance information.

Part 2: Child's Health History, Examination & Recommendations.

Health Provider: Form must be fully completed.

Form for Part 2: Child's Health History, Examination & Recommendations, including fields for Date of Health Exam, Health Concerns, and Annual Dentist Visit.

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

B. Significant allergies or health conditions that may require emergency medical care at school, childcare, camp, or sports activity. NONE YES, please detail:

C. Long-term Medications or special care requirements or accommodations. NONE YES, please detail: (Please specify medication dosage/time/administration instructions and common side effects if given at school/child care)

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 childcare activities except as noted above. ATHLETE IS CLEARED FOR COMPETITIVE SPORTS: YES NO

Part 3: Immunization Information: (Please fill in or attach equivalent copy with provider signature and date)

Table for Part 3: Immunization Information, listing various vaccines and their status (e.g., DTP/DTaP-1, Hib1, Polio, MMR1).

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing If PPD Positive:

Form for Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing, including TB Exposure Risks and Lead Exposure Risks.

Part 5: Required Provider Certification and Signature

Form for Part 5: Required Provider Certification and Signature, including Age-Appropriate Health Screening Requirements and Medical Exemption From Immunization.

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

Form for Part 6: Required Parental/Guardian Signatures, including a statement of permission to share health information.

This form replaces all forms dated before February 25, 2004, used for entry into DC Schools.

Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form, formally the Dental Appraisal Form. This form was developed by the DC Department of Health and follows American Academy Of Pediatrics (AAP) Guidelines For Child And Adolescent Health Care Birth to 21 Years Of Age. **This form is a confidential document.** Confidentiality is adherent to *The Health Insurance Portability and Accountability Act of 1996 (HIPAA)* for the health providers, and *The Family Educational Rights and Privacy Act (FERPA)* for the DC Schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's personal information:

Parent or Guardian: Please check the box that best fits the description of the child's race or ethnicity. Please indicate the ward of your home address. List primary care provider and type of health insurance coverage. If child has no provider or 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 health history, Examination & Recommendations: To be completed by the health care provider. Please mark all relevant boxes.

- **Date of complete health exam:** All children **MUST** have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate that the child is in compliance with these requirements outlined in DC Law 6-66.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG) **HT:** Child's height in either inches (IN) or centimeters (CM)
- **BP:** If child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal please provide explanation and resolution in part 2 section "A."
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is required For Head Start children. Anemia screen is recommended for menstruating adolescents based on AAP guidelines. Please record level and indicate by circling HGB or HCT.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens dental-oral health, asthma, development, behavioral/emotional, learning/attention, language/speech, vision, hearing, nutrition, and "neurologic disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. If there are **NO** "HEALTH CONCERNS" then please mark the 'None' Box in each screen area. **SPECIAL NOTE: 'Dental-Oral Health' refers to the screening done by a primary care provider. This does not replace a comprehensive oral examination provided by a dentist. For children age three and older the health care provider must also indicate whether dentist has screened or examined the child within the last 12 months. If no, child should be referred to dentist.**

- A. Please note any significant health history, conditions, communicable illness, or restrictions that may affect the activity or program **OR mark 'NONE'.**
- B. Please note any significant allergies or health conditions that may require **emergency medical care** at the activity or program **OR mark 'NONE'**
- C. Please note any long-term medications or special care requirements or accommodations **OR mark 'NONE'.** (For medications that require administration at activity or program, please specify dosage/ timing / administration instructions and common side effects of each medication).

Athlete is cleared for competitive sports based on the assessment in the AAP Preparticipation Physical Evaluation 2nd Ed. (1997); Check YES or NO. This will cover patient for ALL YEARLY PHYSICALS for competitive sports.

Part 3: Immunization Information:

All areas of this section must be completed or an equivalent form attached with the physician's or health care provider's signature.

As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised 03/21/97), the following immunizations are required. Medical exemptions from immunizations may be granted for valid reasons with proper documentation and certified and signed by the health care provider in Part 5.

DOH Immunization Program: 202-576-7130

Summary of REQUIRED Cumulative Number of Doses of Vaccine for PRESCHOOL aged children ¹				Doses Must Be Appropriately Spaced and Given at Appropriate Age				
Age of Child	DTaP/DTP/DT/Td ²	Polio ³	Hib ⁴	Hepatitis B	Pneumococcal ⁵	MMR ⁵	Varicella ⁶	
Less than 2 Months	0	0	0	0	0	0	0	
2-3 Months	1	1	1	1	1	0	0	
4-5 Months	2	2	2	2	2	0	0	
6-11 Months	3	3	3	3	3	0	0	
12-17 months	4	3	3 or 4	3	4	1	1	
18-60 Months	4	3	3 or 4	3	4	1	1	

Summary of REQUIRED Cumulative Number of Doses of Vaccine for Children in GRADES KINDERGARTEN – 12 ¹				Doses Must Be Appropriately Spaced and Given at Appropriate Age				
Grade Level	DTaP/DTP/DT/Td ²	Polio ³	Hib ⁴	Hepatitis B	MMR ⁵	Varicella ⁶		
Grade If Ungraded								
Kindergarten (5 years)	5	4	Not required	3	2	1		
Grades 1 & 2 (6-7 years)	5	4	Not required	3	2	1		
Grades 3 - 5 (8-10 years)	5 doses or ≥3 doses Td	4	Not required	3	2	1		
Grades 6 – 12 (11-18+ yrs)	5 doses or ≥3 doses Td plus 1 Td booster if 10 years since last dose	4	Not required	3	2	<13 yrs = 1 dose > 13 yrs = 2 doses		

All religious exemptions must be submitted to the school Principal & must be accompanied by a signed notarized statement from parent or guardian. Child care and Head Start children must obtain exemptions from child care or Head Start Director.

²DTaP/DTP/DT/Td: 5 doses of DTaP/DTP are required for school entry unless the fourth dose is given on or after the 4th birthday. Three (3) doses of Td required if primary series started after 7th birthday. Td booster required every 10 years.

³Polio: Four doses are required for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which case only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are always required to complete the primary series. Polio not routinely required for students >18 years of age.

⁴Hib: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age; however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.

⁵MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and varicella must be given on the same day or separated by at least one month.

⁶Varicella: The varicella vaccine is not required for a student who has a reliable history of disease. One dose is required for students 12 years old or younger at the time of vaccination. If students is ≥13 years of age at time of vaccination, 2 doses are required. MMR and varicella must be given on the same day or at least one month apart.

⁷Pneumococcal Vaccine: Recommended for all children age 2 to 23 months. The number of primary doses is determined by age series begins. The final dose in the series should be given at age > 12 months. It is also recommended for certain children age 24 to 59 months.

Part 4: Tuberculosis & Lead Exposure Risk Assessment & Testing:

- **TUBERCULOSIS EXPOSURE RISKS?** Please assess risk of ALL patients for Exposure to Tuberculosis as defined by the AAP *Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2003 AAP RED BOOK page 646*. **Current DC regulations require ONE PPD (Purified Protein Derivative) Test** for all children entering child care or school, whichever comes first. PPD Test is also required for all children who are assessed as **HIGH RISK OF EXPOSURE**. Please note date of test and mark outcome of test (negative or positive). **IF PPD IS POSITIVE**, then mark outcome of chest X-Ray (CXR) and if child was treated. **ALL POSITIVE PPD tests MUST BE Reported to DC T.B. Control at 202-698-4040.**
- **LEAD EXPOSURE RISKS?** Please assess risk of ALL patients for exposure to lead using the AAP *Statement " Screening for Elevated Blood Lead Levels" (1998)*. All children require a lead test between 9 and 12 months of age and again at 24 months of age. All children between 26 months and 6 years who have not had a lead test require at least **ONE** documented lead test unless assessed as HIGH RISK OF EXPOSURE. Please document "Date" of most recent test and "Result". Please indicate if "Pending". "Pending" results will be **valid for two months from date of testing** and will NOT exclude child from activity or program. **ALL lead tests must be reported to DC Lead Poisoning Prevention by Fax: at 202-535-1398.**

Part 5: Required Provider Certification and Signature

All information will be kept confidential. A physician or nurse practitioner must complete this part. By checking the yes box the provider certifies that the child has received age-appropriate screenings according to AAP and EPSDT guidelines within the current year. If no is checked please explain reason in space provided.

Part 6: Required Parental/Guardian Signatures. (Release of Health Information)

- ♦ **The parent or guardian must print, sign, and date this Part.** By signing this section the parent or guardian gives permission to the health examiner or facility to share the health information on this form with the child's school, childcare, camp, DOH, or the entity requesting this document.



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ENROLLMENT INFORMATION SHEET

Date _____

Child's name _____

Name child is usually called _____

Child's birth date _____ Sex _____

A. Personal History

Parent name _____ Occupation _____

Parent name _____ Occupation _____

Sibling(s)' names:

Birth dates:

B. Experiences and Characteristic Ways of Behaving

1. How many other homes has your child had?
2. Does your child play frequently, occasionally or rarely with other children his/her age?
3. What other experiences has your child had in care while you work?
4. What pets, if any, do you have in your home?
5. Under what circumstances does your child become easily upset or concerned?

6. What helps reassure him/her when upset?
7. What fears does your child have?
8. To what methods of setting limits does your child respond?
9. Check the adjectives below which you feel are the most characteristic of your child at the present time.

- | | | |
|---------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> active | <input type="checkbox"/> determined | <input type="checkbox"/> intelligent |
| <input type="checkbox"/> affectionate | <input type="checkbox"/> happy | <input type="checkbox"/> patient |
| <input type="checkbox"/> aggressive | <input type="checkbox"/> high strung | <input type="checkbox"/> pleasant |
| <input type="checkbox"/> agile, deft | <input type="checkbox"/> independent | <input type="checkbox"/> quarrelsome |
| <input type="checkbox"/> bored | <input type="checkbox"/> impatient | <input type="checkbox"/> quiet |
| <input type="checkbox"/> clumsy | <input type="checkbox"/> impudent | <input type="checkbox"/> relaxed |
| <input type="checkbox"/> cooperative | <input type="checkbox"/> impulsive | <input type="checkbox"/> secretive |
| <input type="checkbox"/> creative | <input type="checkbox"/> irritable | <input type="checkbox"/> slow thinking |
| <input type="checkbox"/> curious | <input type="checkbox"/> likeable | <input type="checkbox"/> sociable |
| <input type="checkbox"/> daring | <input type="checkbox"/> messy | <input type="checkbox"/> stubborn |
| <input type="checkbox"/> demanding | <input type="checkbox"/> meticulous | <input type="checkbox"/> talkative |
| <input type="checkbox"/> enthusiastic | <input type="checkbox"/> moody | <input type="checkbox"/> thoughtful |
| <input type="checkbox"/> excitable | <input type="checkbox"/> musical | <input type="checkbox"/> whiny |
| <input type="checkbox"/> fastidious | <input type="checkbox"/> negative | <input type="checkbox"/> timid |
| <input type="checkbox"/> fearful | <input type="checkbox"/> obedient | <input type="checkbox"/> worried |

Other (please specify):

10. Which activities does your child particularly enjoy?

- | | | | |
|-----------------------------------|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> painting | <input type="checkbox"/> walks | <input type="checkbox"/> puzzles | <input type="checkbox"/> coloring |
| <input type="checkbox"/> dress up | <input type="checkbox"/> singing | <input type="checkbox"/> blocks | |
| <input type="checkbox"/> park: | <input type="checkbox"/> slide | <input type="checkbox"/> swing | <input type="checkbox"/> climbing |
| <input type="checkbox"/> games: | <input type="checkbox"/> hide & seek | <input type="checkbox"/> duck, duck, goose | <input type="checkbox"/> other? |

11. What characterizes her/his social interactions with adults?

___ accepting

___ imaginative

___ instigative

___ affectionate

___ independent

___ willful

___ demanding

___ other:

C. Food Preferences

1. Is your child allergic to any foods now? If not, please answer “no.” If so, please list:
2. What foods are favorites?

D. Patterns of Sleeping

1. When does she/he go to bed at night?
2. When does she/he get up in the morning?
3. Are there any difficulties at nap or bedtime? If so, please describe:
4. Does she/he have any favorite comforting devices, such as bottle, blanket or toys she/he uses in going to sleep?

E. Languages

1. Is your child exposed to any languages other than English? If so, which ones?
2. Does your child have any special words to describe needs?

F. Toilet Training

1. What words does your child use for urination?
2. What words does your child use for bowel movements?
3. He/she indicates bathroom wishes... ___ all the time ___ sometimes
 ___ most of the time ___ never

G. Physical Health

1. Does your child have any difficulties of vision, hearing, motor skills or unusual abilities or disabilities of which you are aware? Please describe:

H. Summary

1. Is there anything else that you can tell us about your child that will help us better understand and help him/her in our care?
2. In what particular ways can we help your child this year?
3. Do you have any interests, hobbies or talents which you would like to share with the children?

Dear Washington DCJCC Preschool Parent,

Thank you so much for choosing our wonderful Preschool. We know the months ahead will be an exciting and enriching time for you and your family. As you know, we ask that all families with children attending the Preschool maintain an active membership at the J. We hope that you will find your J membership opens doors throughout the building and offers a variety of programs, events and activities for every member of your family.

You may choose either a Fitness or a Community Membership. Fitness Membership entitles you to everything that we have to offer, including unlimited access to our fitness center, pool, gymnasium, Members Only group exercise classes, racquetball and squash courts, and our famous steam rooms. Fitness Membership fees vary; there are a variety of payment plans and discounts available. The Family Community Membership is \$329 annually and \$230 for Single Parent Family Community Membership.

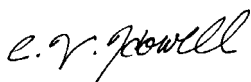
All J Memberships entitle you to discounts—almost always more than 30% off the price paid by the general public—on performances, events, lectures, classes, workshops, retreats and more and more and more.

To complete your J membership, please fill out the attached application including your preferred payment method. Be sure to stop by the Member Services Office so that we can give you your photo ID to access the building and your free guest passes to our fitness facilities. The Member Services Office is open 10:00 am–9:00 pm Monday–Thursday and 10:00 am–3:00 pm Friday and Sunday; we are closed on Saturday. If you have any questions, you may reach our Member Services Office at telephone (202) 777-3218 or email alexcs@washingtondcjsc.org

You will need to join the J before or during your child's first week of school (i.e. September 2-5, 2008).

Again, thank you for choosing the Washington DCJCC Preschool.

Sincerely,



Tena Howell, Director
Member Services