creative minds
INTERNATIONAL
PUBLIC CHARTER SCHOOL

April 7, 2020

Dear Creative Minds International PCS Family,

We miss seeing your child. I hope that you are doing well and staying healthy. We are excited that you have decided to return for the 2020-2021 school year. Please note that the COVID-19 pandemic has impacted enrollment. The deadline for enrollment is one month after the re-opening of DCPS schools during the 2019-20 school year, or Monday, June 15, 2020 at 5:00 p.m., whichever is earlier. Currently, the deadline is May 27, 2020.

There are two options to enroll. I am excited to announce that we are rolling out an online enrollment option, which should have reduced paperwork, especially if you have multiple children at CMI. Option 1 is to use the new online enrollment form. Option 2 is to use the traditional paper or pdf enrollment. For option 1, you can access directly through the parent portal in Power School. Complete the forms online and upload attachments such as proof of residency and the Universal Health Certificate. The final step is to look for an email to sign the documents using secure encryption via Docusign. For option 2, please print the attached file or to have a packet mailed to you, contact the school. Then complete the paperwork and gather the forms. Forms maybe returned via email at frontdesk@creativemindspcs.org, mailed to the Registrar; 3700 N Capitol St NW, Sherman Bldg. 217; Washington, DC 20011, or dropped off in person via appointment. Note that the in-person option will not be available if the DC mayor has issued a district-wide stay-home or shelter-in-place order. If you have any questions, please email frontdesk@creativemindspcs.org or call 202-588-0370.

Each year, every student must meet the DC-residency requirement. You may verify residency by providing documents such as your most recent pay stub or driver's license and registration; a list of acceptable documents is included in this packet or in the online enrollment. We are required to make copies of residency-verification documentation for your child's file or you may upload directly to Power School.

Immunization and health paperwork are due at the time of enrollment. These must be renewed annually, on your child's birthday. Please check with your pediatrician to ensure that immunization and health records are up to date. Beginning in the 2020-21 school year, DC is implementing the No Shots, No School policy. If we don't receive health and immunizations documents by the 20th day of school, your child may need to stay home until the documents have been submitted.

If you have any questions or need a translator, please contact me directly, at heather.hesslink@creativemindspcs.org or (202)588-0370 ext. 112. You may also schedule an appointment if you need help completing the forms. Thank you for choosing the Creative Minds community, and enhancing our diverse, inclusive family.

Respectfully,
Heather Hesslink
Director of Operations & Compliance

Contents of Packet and Item Checklist for Returning Students

(Note Items in bold must be returned to CMI)

Contents of this packet

Welcome Letter
Content Packet and Item Checklist
Enrollment Instructions
___**CMI Enrollment Form**
___**CMI Singular Enrollment**
Residency Verification Guidelines
___**DCRVF** (only wet signatures or via encrypted digital signatures are acceptable)
___**Emergency Contacts**
___**Home Survey**
___**Campus Access & Parking Pass** (please complete for passes currently in your possession as well as for new ones; up to four requests can be submitted per family)
___**Dietary Accommodations**
___**Medical forms** (Universal Health Certificate, Oral Health Assessment, Medication Treatment Plan)
___**HPV Opt-out Form** (6-8th grade only)
___**Consent to Share Health Info**
___**Student Directory**
___**Photo Release/Military opt-out**
___**Technology Policy**
___**Opt-in for SMS Text Message Notifications**
Notification of Rights under FERPA
Notification of Rights of PPRA
DC Health Information
Meeting Your Child's Medication & Treatment Needs at School
HPV Fact Sheet

Additional Items to Submitted

___**Proof of DC Residency** (see residency verification guidelines for acceptable documentation)
___**Driver's License and Vehicle Registration** (for each Parking Pass request)

Creative Minds International Public Charter School
Sherman Building, 3700 North Capitol St NW, Washington DC 20011
Phone (202)588-0370 Fax (202)588-0263

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INTERNATIONAL
PUBLIC CHARTER SCHOOL

Returning Student Enrollment Instructions for SY2020-21

Due to COVID-19, the deadline for enrollment is one month after the re-opening of DCPS schools during the 2019-20 school year, or Monday, June 15, 2020 at 5:00 p.m., whichever is earlier.

Option 1: Online via Power School
(Preferred Method, new for 2020-21)

1. Request a password
2. Access your account via email directions)
3. Complete online forms
4. Upload the following documents
   a. Birth certificate
   b. Proof of DC residency
   c. Driver's License & registration (for Parking Pass)
   d. Universal Health Certificate (if available)
   e. IEP/504 (if applicable & available)
5. Check your email and sign via Docusign
   a. DCRVF
   b. CMI singular enrollment
   c. CMI enrollment form
   d. My School DC Seat Acceptance

Option 2: Paper/PDF

1. Print attached package or request paper copy to be mailed
2. Complete the Enrollment Packet
3. Physically sign all forms (wet signature)
4. Gather other required documents
   a. Birth certificate
   b. Proof of DC residency
   c. Driver's License & registration (for Parking Pass)
   d. Universal Health Certificate (if available)
   e. IEP/504 (if applicable & available)
5. Return forms to CMI via one of the following methods:
   a. Scan and email to frontdesk@creativemindspcs.org.
   b. Mail to Registrar
   3700 N Capitol St NW, Sherman Bldg 217
   Washington DC 20011
   c. Make an appointment to drop off forms (not an option if there is a city-wide shelter-in-place order)

If you have any questions, please contact our registrar at frontdesk@creativemindspcs.org or at (202)588-0370 x 120.

School Name: Creative Minds International PCS

ANNUAL STUDENT ENROLLMENT FORM

School Year 2020-21

(Print or type all information)

STUDENT INFORMATION

Last Name	First Name	Middle Name	Preferred Name

Ethnic Designation:
o Hispanic/Latino
o Non-Hispanic/ Non-Latino

Race (choose one or more):
o American Indian/Alaska Native
o Asian
o Black/African American
o Native Hawaiian/Pacific Islander
o White

Date of Birth (mm/dd/yyyy) / /

Student's Gender
o Male o Female

Phone number: ( )

Country of Birth (if other than US):

Students New to CMIPCS

Street Address	Apt. No.

City	State	ZIP

Grade Level next school year (20-21)

Previous School (if not CMIPCS):
City, State, Zip:

Current IEP for Special Education services	o Yes	o No
Current 504 plan	o Yes	o No
Allergies *(if "yes", please complete form)*	o Yes	o No
Dietary restrictions *(if "yes", please complete form)*	o Yes	o No
Required medications *(if "yes", please complete form)*	o Yes	o No

PARENT/GUARDIAN INFORMATION

Parent/Guardian	Relationship

Street Address

City	State	Zip

Email Address	

Home Phone	Cell Phone	Work Phone

Other Parent/Guardian/Contact	Relationship

Street Address

City	State	Zip

Email Address	

Home Phone	Cell Phone	Work Phone

SIBLING INFORMATION

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Name				
School				

CMIPCS agrees that the data/information provided in the Student Enrollment Form remain confidential and shall only be used for legitimate CMIPCS business. **I completed this form and I certify that the information above is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law. By signing below, I acknowledge my agreement with any consents provided in this form. Form should not be signed prior to April 1.**

_____ _____

Signature of Enrolling Parent/Guardian **Date**

Parent/Guardian Confirmation of Singular Enrollment SY2020-21

Note to school staff: This form addresses three possible objectives:

1. To confirm that a student enrolling in your school for 2019-20 is not already enrolled elsewhere for SY2019-20;
2. To inform a parent whose child ***is*** already enrolled elsewhere for 2019-20 that they must formally withdraw their student from that school in order to formally enroll at your school;
3. To inform the parent of a student enrolling at your school that - should they subsequently decide to enroll their child at another school instead - they will need to formally withdraw from your school in order to do so.

You should maintain this record to facilitate your communication with other schools and with PCSB, in the event of a duplicate enrollment.

The parent or guardian of the student should complete the following section.

Name of enrolling student _____ *Grade* _____

Student's date of birth _____

Name of school where you are enrolling student for 2020-21 school year - ***Creative Minds International PCS***

Please choose and complete the appropriate box below:

Enrollment Only

☐ The student named above is **not** currently enrolled* at any school other than the above-named school for 2020-21. Should I decide to enroll them elsewhere, I will contact the above-named school and formally withdraw my enrollment.

_____
Name of parent or guardian

_____
Signature of parent or guardian

_____
Date

Enrollment and Intent to Withdraw from Another School

☐ The student named above is currently enrolled* at a school other than the above-named school for 2020-21. I will contact that other school and formally withdraw my enrollment.

_____
Name of other school at which student is enrolled

_____
Name of parent or guardian

_____
Signature of parent or guardian

_____
Date

*Students may remain on waitlists at other schools; this form addresses only enrollment.

School staff should complete this portion.

Unique Student ID for above named student _____

Name of school staff member_____

Signature_____ Date_____

Note to school staff: If the parent completed the right hand box above, you are encouraged to fax this form to the school named in that box and work with that school to resolve any duplicate enrollment.

Enrolling person, follow ONE of the methods (A-C) to verify your DC residency.

A

Verify with a school official. If you are experiencing homelessness, a ward of the District, and/or a participant of a District public benefits program, such as Medicaid, Supplementation Nutrition Assistance Program, or Temporary Assistance for Needy Families – your school may already have your information. Check with your school official or the school's homeless liaison.

Verify through the Office of Tax and Revenue (OTR). Re-enrolling families/students are often able to verify residency using OTR residency verification process. The enrolling person must have paid taxes in DC during the previous fiscal year and have the student's Social Security number. The student must be re-enrolling in the same local education agency and enrolling in grades K-12. Login to the system at ossedctax.com. If successful, your verification will then be available for your school to confirm.

B

Verify by submitting supporting documentation. *All* items must include the same name and address of the enrolling person as completed on the DC residency verification form and school-based enrollment documents.

ONE item is needed from this list to verify residency.

- A valid **pay stub** issued within 45 days of the school's review of this form. Must contain withholding of only DC personal income tax for the current tax year and no other states listed for deduction, even if the amount is zero. It must also show a DC personal income tax withholding amount greater than zero for both the current tax year and current pay period.
- **Unexpired official documentation of financial assistance from the Government of the District of Columbia,** issued to the enrolling person within the past 12 months and current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs.
- **Certified copy of Form D40** by the DC Office of Tax and Revenue, with evidence of payment of DC taxes for the current or most recent tax year and must bear the DC Office of Tax and Revenue stamp.
- **Current military housing orders or statement on military letterhead**, must be official correspondence and cite the specific DC address of residence.
- **Embassy letter** issued within the past 12 months. Must contain an official embassy seal and signature of embassy official; and indicate that the enrolling person and student or the adult student currently reside, or will reside, on embassy property in DC during the relevant school year.

OR

TWO items are needed from this list to verify residency.

- **DC motor vehicle operator's permit** or official government-issued non-driver identification that is valid and unexpired.
- **DC motor vehicle registration** that is valid and unexpired.
- **Lease or rental agreement** that is valid and unexpired **with a separate proof of payment of rent**, such as receipt of payment, money order, or copy of cashed check.
  The lease must contain the start date, monthly rent amount, name of landlord, and be signed by the enrolling person and landlord.
  The separate proof of payment must be for a period within two months immediately preceding the school's review of this form and match the monthly rent amount stated on the lease.
- **Utility bill** (***only gas, electric, and water bills are acceptable***) **with a separate paid receipt showing payment of the bill**, such as receipt of payment printout, money order, or copy of cashed check.
  The utility bill must be for a period within the two months immediately preceding the school's review of this form.
  The separate proof of payment must be for the specific bill submitted. The most common submission is two consecutive bills where the second bill shows payment on the first bill. A credited amount on a bill and government agency letter subsidizing payment for utility are also acceptable proofs of payment.

C

Verify through a home visit. If you are unable to verify through one of the above methods, speak with your school official about a home visit.

Enrolling as a non-resident student

Non-resident students are only eligible to attend a District public school if there are no eligible DC residents on the waitlist, the LEA agrees to enroll the student, there is a signed tuition agreement in place with the Office of the State Superintendent of Education, and an initial tuition payment has been made. To complete a tuition agreement and tuition payment, please email osse.residency@dc.gov. Non-residents are not eligible for enrollment through the District's Pre-K Enhancement and Expansion Funding Program.

Persons eligible to enroll a student.

- **Parent** - a natural parent, stepparent, or parent by adoption who has custody or control of a student, including joint custody.
- **Guardian** - an appointed legal guardian of a student by a court of competent jurisdiction.
- **Custodian** - a person to whom physical custody has been granted by a court of competent jurisdiction.
- **Other Primary Caregiver** - is a person other than a parent or court-appointed custodian or guardian who is the primary provider of care or control and support to a student who resides with him or her, *and* whose parent, custodian, or guardian is unable to supply such care and support due to serious family hardship.
- **Adult Student** - A student who is 18 years of age or older, or who has been emancipated from parental control by marriage, operation of statute, or the order of a court of competent jurisdiction.

DC Residency Verification Form –2020-21 School Year

Use this form to verify that you are a District resident and therefore you or your student is eligible to enroll in a DC public or public charter school. All forms and supporting residency documentation are submitted to the enrolling school.

Step One: Choose the residency verification method that best applies to you.

Details of the available methods for verifying your DC residency are provided on page two. **Choose ONE** after completing sections 2 and 3 below. To be eligible to enroll in a DC public or public charter school tuition-free: 1) the enrolling person must be the parent, adult student, or the valid legal guardian, custodian or Other Primary Caregiver with proper documentation; 2) **the enrolling person has established a physical presence in the District of Columbia**; and 3) the enrolling person has submitted valid and proper documentation that establishes residency as set forth in law and regulations.

Step Two: Provide information about student and enrolling person.

Student First Name:	**Student Last Name:**	**DOB:**
Name of 2020-21 School Year School:		
Enrolling person > First Name:	**Last Name:**	

I am the:
- ☐ student's legal parent/guardian/custodian
- ☐ adult student
- ☐ student's Other Primary Caregiver and completed the OPC Form
- ☐ minor parent and completed the sworn statement

Address of enrolling person:

City:	**State:**	**ZIP:**	**DC Resident:** ☐ **Yes** ☐ **No**
Email:		**Phone:**	

Step Three: Sign Certification of Residency Requirements.

- I certify that I am the parent or the valid guardian, custodian, or Other Primary Caregiver and am submitting valid and proper residency documentation accordingly or have identified myself as a non-resident and understand the required tuition agreement and tuition payment needed for enrollment.
- I certify that I have established and will maintain a physical presence in the District, defined as the "actual occupation and inhabitance of a place of abode with the intent to dwell for a continuous period of time"; and I am submitting valid and proper documentation to verify residency, as set forth in 5-A DCMR § 5004; or, I have identified myself as a non-resident and will complete the required tuition agreement and tuition payment.
- I consent to the disclosure of residency information if enrolled in a government-funded financial assistance program (Medicaid, TANF, SNAP) for the sole purpose of verifying District residency. By signing below, I am saying: I authorize the Office of the State Superintendent of Education (OSSE) to obtain my personally identifiable information from other state or federal agencies, including but not limited to, the DC Department of Human Services (DHS), the DC Housing Authority (DCHA), and the Department of Health Care Finance (DHCF). OSSE will protect my information and follow all applicable laws regarding the protection and use of this information.
- I understand that enrollment of the above-named student in District of Columbia Public Schools, public charter schools, or other schools providing educational services funded by the District of Columbia is based on my representation of **bona-fide DC residency, including this sworn statement of physical presence and my submission of valid and proper documentation verifying residency** or by completion of a tuition agreement and tuition payments.
- I understand that even if the documentation I provide appears to be satisfactory, OSSE or school officials, with reasonable basis, may seek further information to verify the student's residency or the Other Primary Caregiver status of the adult enrolling the student.
- If the District of Columbia, through OSSE, determines that I am not a resident or an approved non-resident under 5-A DCMR § 5007, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school.
- I understand that if I provide false information or documentation, I can be referred to DC Office of the Inspector General for criminal prosecution or to the DC Office of the Attorney General for prosecution under the False Claims Act and under D.C. Code § 38-312 which provides that any person who knowingly supplies false information to a public official in connection with student residency verification shall be subject to payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both a fine and imprisonment.
- I understand that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies including but not limited to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request.
- I am aware that the District of Columbia may use whatever legal means it has at its disposal to verify my residence and I consent to the disclosure of residency information to the appropriate local authorities for verification and/or investigation.
- **I agree to notify the school of any change of residence for myself or the student within three school days of such change.**

Enrolling Person SIGN HERE: _____ **DATE:** _____

Step Four: Bring this completed form and applicable documentation to your school.

SCHOOL OFFICIAL USE ONLY The following method was used to verify District of Columbia residency. Choose ONE method.

I certify, under the penalties of perjury, that I have personally reviewed all the documents presented and affirm that the information represented above is true to the best of my knowledge, information, and belief. I also affirm that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies, including but not limited, to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request.

School Official Name (print): _____ **Signature:** _____ **Date:** _____

Method A: School official verified
- ☐ OSSE Residency Verified (QLIK or ASPEN)
- ☐ Homeless liaison verified
- ☐ Ward of DC

Method B: Select one document
- ☐ Pay stub
- ☐ DC Gov. financial assistance
- ☐ Certified DC Tax Form-D40
- ☐ Military housing orders
- ☐ Embassy letter

Method B: Select two documents
- ☐ DC motor vehicle registration
- ☐ DC driver's license/non-driver ID
- ☐ Lease with payment
- ☐ Utility bill with payment

☐ **Method C:** Home visit

☐ Non-resident

Emergency Contacts

Emergency Contact 1

Name	Relationship
Street Address	City, State, Zip
Cell Phone	SMS Text ☐ Yes ☐ No
Home Phone	Work Phone
Authorized School Pick-up ☐ Yes ☐ No	

Emergency Contact 2

Name	Relationship
Street Address	City, State, Zip
Cell Phone	SMS Text ☐ Yes ☐ No
Home Phone	Work Phone
Authorized School Pick-up ☐ Yes ☐ No	

Emergency Contact 3

Name	Relationship
Street Address	City, State, Zip
Cell Phone	SMS Text ☐ Yes ☐ No
Home Phone	Work Phone
Authorized School Pick-up ☐ Yes ☐ No	

Home Survey

Internet Connectivity at Home

Does your child have access to reliable internet?	☐ Yes ☐ No
Does your child have access to device that is not a phone to complete schoolwork?	☐ Yes ☐ No

Housing Status

What is your housing status? (check all that apply)		
☐ Permanent	☐ Hotel/Motel	☐ Shelter
☐ Unsheltered	☐ Doubled Up	☐ Foster Care/CFSA
☐ Awaiting Foster Care	Unaccompanied Youth	

Campus Access & Parking Pass Form
School Year 2020-21

To access the AFRH campus, your information must on file. **Please complete this form and provide a copy of your driver's license and vehicle registration.** For those who plan to walk or bike, please provide information about a government-issued ID (e.g., driver's license, military ID, state ID card, etc.)

General information

Adult name _____ Pass purpose (circle one) car / walk / bike

Adult cell phone # _____ Student name _____

Driver's license or government-issued ID for biking or walking

Driver's license _____ State of issue _____

Driver license # _____ Expiration date _____

Vehicle information

Vehicle make _____ Plate number _____

Vehicle model _____ Plate state of issue _____

Vehicle color _____ Plate expiration date _____

I understand that driving on the Armed Forces Retirement Home, which is a federal property, is a privilege. Base rules include a speed limit of 15 miles per hour, no cell phones, and no driving under the influence. If I violate these rules or the rules of the road, I my driving privileges may be revoke.

Signature _____ Date _____

For Official Use (Do not write below line.)

Pass # _____ Pass returned Y / N

Pass color/type _____ Pass lost or stolen Y / N

Date pass issued _____ Replacement Pass. Y ? N

Creative Minds International Public Charter School
Sherman Building, 3700 North Capitol St NW, Washington DC 20011
Phone (202)588-0370 Fax (202)588-0263

SY 20/21 Dietary Accommodation Request Form

Use this form to alert CMIPCS of the dietary accommodations your student needs for the school year. This form is not intended to accommodate student taste preferences. **Please provide this form to your student's school nurse.** You will be contacted by the food service staff via email when your request is fulfilled.

A. Student Information.

First Name:	**Last Name:**
Date of Birth	**Student ID:**

Grade Level for School Year 2020/21: *(check only one)*

☐ Pre-K3 ☐ Pre-K4 ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th

B. Student's Dietary Accommodations. *Check all that apply.*

☐ **A. Milk Substitution**: The student is requesting a milk substitute due to a medical or other special dietary need. CMIPCS has the discretion to select a specific brand of milk substitute, provided it meets specified USDA nutrient requirements. Juice cannot be offered as a milk substitute. The CMIPCS cafeteria serves only nut-free items, so nut milks are not available.

☐ **B. Philosophical Accommodation:** The student is requesting dietary accommodations for philosophical reasons, such as following a plant-based diet. **Dietary instructions, including list of foods to be omitted:** _____

_____

☐ **C. Food Intolerance/Medical Accommodation:** The student is requesting a dietary accommodation due to food intolerance(s) or other medical reasons. Please be advised that the CMIPCS cafeteria serves only nut-free items. ***A medical practitioner must complete the section below.***

Completed by Medical Practitioner for Option C

What is the student's medical condition and why does it restrict their diet? *(e.g. Type 1 Diabetes; allergy to wheat or fish.)*

_____

_____

_____

Food texture required: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Is the food allergy airborne? ☐ Yes ☐ No

Foods to omit:	Suggested Substitutions:

Medical Office Stamp

Medical Practitioner Name: _____

Medical Practitioner Signature: _____

Date: _____ **Medical Practitioner ID:** _____

C. Parent/Caretaker Signature

I confirm all the information provided above is correct to the best of my knowledge. I understand that the information on this form will remain in effect until the end of the school year for which it is received. When necessary throughout the school year, I will update this form to reflect changes in my student's medical and/or nutritional needs. I understand that CMIPCS may have discretion as to whether it is able to accommodate these requests.

Printed Name: _____ **Signature:** _____ **Date:** _____

Phone: _____ **Email:** _____

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 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.

DC | HEALTH

Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

Student First Name:	**Student Last Name:**	**Grade:**
School Facility Name:		**Student DOB:**
Parent First Name:	**Parent Last Name:**	
Parent Email:		**Parent Phone:**

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	**End date for school administration of this medication:**

This medication is: ☐ New; the first dose was given at home on date and time: _____ ☐ Renewal ☐ Change

Is this a standing order?

☐ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
☐ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
☐ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
☐ Yes, other: _____
☐ No

Name and strength of medication:	**Dose/route:**

Time and Frequency at School *(e.g. 10am and 2pm every day; as needed if standing order)*

If a reaction can be expected, please describe:

Additional instructions or emergency procedures:

Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

Diagnosis:	**This procedure is:** ☐ New ☐ Renewal ☐ Change

Treatment:

When should treatment be administered at school? *(e.g. 10am and 2pm every day)*

End date for school administration of this treatment:

Additional instructions or emergency procedures:

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ☐ Yes ☐ No

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

OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

Name:	**Signature:**	**Date:**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Annual Human Papillomavirus (HPV) Vaccination Opt-Out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School			
Student Name:		Date of Birth:	Grade:
Street Address:	City:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C. Law 17-10 (Human Papillomavirus Vaccinations and Reporting Act of 2007) and the December 19, 2014 Notice of Rulemaking to expand Title 22 of the DC Municipal Regulations, the parent or legal guardian of a student enrolling in grades 6 through 12 for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine this school year because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school with written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Signatures

Annual Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls and boys. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, other cancers and genital warts, I have decided to opt-out of the HPV requirement for the above named student. I know that I may readdress this issue at any time and complete the required vaccinations.

_____ _____
Signature of Parent/Guardian or Student if >18 years Date

_____
Print Name of Parent/Guardian or Student if >18 years

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Consent to Share Student Health Educational Records SY2020/21

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. The purpose of this consent is to allow key school–based staff members *(such as the principal, school nurse, nurse case managers, 504 Coordinators, and Special Education staff members)* who work with your child to share health-related educational records with external health-related agencies and healthcare providers, including school-based health centers *(if there is one located in your school)*. These staff members and health care providers would then be able to better coordinate health-related services for your child. Coordinated services will better ensure that your child's needs are met, and that he/she can fully participate in the school's learning environment. **IF YOU AGREE TO THIS CONSENT, PLEASE COMPLETE, SIGN AND RETURN IT TO THE REGISTRAR AT YOUR CHILD'S SCHOOL.**

(Student/Child's Name)	(School Name)	(Date of Birth)
(Grade)	(Student ID, if known)	

1. I authorize the Creative Minds International PCS (CMIPCS) to share the educational records regarding my child specified in Section 3 below with each of the following agencies and organizations:

*DC Department of Health,
*DC Department of Mental Health,
*DC Department of Health Care Finance,
*DC Department of Human Services,
*Your child's health care provider(s), and
*Other health service providers who deliver services in the school

2. I understand that this information may be used ONLY for the following purposes:

* Planning and providing coordinated educational and health related services, and
* Evaluating programs serving my child and the services provided to my child.

3. I authorize the use/disclosure of each of the following records:

*School nurse records,
* IFSP/IEP documents,
* 504 Plans,
* Class schedule,
* Attendance records,
* Grades, observations and other educational information contained in student records,
* Current Medication orders (retained by the school nurse),
* Eye medical reports,
*Audiology reports, and
*Nursing care plan (as part of IEP or 504 Plan)

4. I understand that:

* This authorization is voluntary and my child will not be refused educational services if I choose not to sign it, and
* I have the right to request a copy of this form after I sign it and to see or copy any information disclosed under this consent.

5. I consent to the use/disclosure of the above information. I understand that this information may not be used for any purposes other than those stated above in Section 2. This consent may be revoked in writing by me at any time. I understand that revoking this authorization will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

(Signature of parent/guardian/student over 18)	(Relationship to the student)	(Date)

This authorization expires one year from the signature date above.

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Release of Student Directory Information SY2020-21

The Family Educational Rights and Privacy Act (FERPA) is a federal law that requires CMIPCS, with certain exceptions, to get your permission before disclosing personally identifiable information from education records. However, CMIPCS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without your consent. The primary purpose of directory information disclosure is to allow CMIPCS to include this type of information in certain school publications such as pamphlets for drama productions, graduation programs, honor rolls or sports team activity sheets for football, basketball, etc. Directory information can also be disclosed to outside organizations such as federal and state agencies offering jobs and educational benefits, media sources, and companies that make class rings and publish yearbooks.

The information listed below has been designated as directory information under District of Columbia law and FERPA, and may therefore be released at the discretion of CMIPCS. You have the right to instruct CMIPCS that it may not release any or all of this information without obtaining your prior written consent by completing this form. Your decision on this form will be valid for the remainder of the current school year. **A new Release of Student Directory Information form must be completed each School Year.**

Please place a checkmark on the line beside the directory information listed below that you do not want CMIPCS to disclose without your consent, if any.

_____Student Name
_____Student Telephone Listing
_____Name of School Attending
_____Participation in Officially
_____Recognized Activities and Sports
_____Weight & Height of Members of Athletic Teams
_____Diplomas and Awards Received
_____Student Address
_____Student's Date and Place of Birth
_____Names of Schools Previously Attended
_____Dates of Attendance

By signing below I am giving written notification to CMIPCS that it may not disclose the directory information items that I have placed a check mark beside unless I give prior written consent. I understand that such information may still be disclosed by CMIPCS if disclosure is otherwise permissible under FERPA.

Student Name _____ Date _____

Parent Name _____ Signature _____

If this form is not returned by September 15th, it is assumed that the above information may be designated as directory information for the remainder of the school year.

Creative Minds International Public Charter School
Sherman Building, 3700 North Capitol St NW, Washington DC 20011
Phone (202)588-0370 Fax (202)588-0263

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Consent and Release for Students to be Filmed/ Photographed/ Interviewed and for Use of Image/Voice/School Work

I, _____hereby grant to Creative Minds International Public Charter School ("CMIPCS"), and its employees and agents,the District of Columbia, their successors, and their assignees the right to record the image and/or voice, and use the artwork and /or written work of my child,_____, on videotape, on film, in photographs, in digital media and in any other form of electronic or print medium and to edit such recording at their discretion. I understand that my child's full name, address and biographical information will not be made public without my express written permission.

I further grant CMIPCS and the District of Columbia, their successors, and their assignees the right to use, and to allow others to use, my child's image and/or voice on the internet, in brochures, and in any other medium and hereby consent to such use.

I hereby release CMIPCS and its employees and agents, as well as the District of Columbia Government, their successors, and their assignees and anyone using my child's image and/or voice, artwork and/or written work pursuant to this release from any and all claims, damages, liabilities, costs and expenses which I or my child now have or may hereafter have by reason of any use thereof. This consent and release form is valid through the end of the summer school session following the school year during which it is signed.

I understand that the provisions of this release are legally binding. (*check one*) ☐ **I consent.** ☐ **I do not consent.**

_____	_____	_____
Parent/Guardian Name [Printed]	**Signature of Parent/Legal Guardian or Student** (if an adult)	**Date**

Right to Opt Out of Release of Information to Military Recruiters (Students in Grades 7–12)

Federal laws require that local education agencies (LEAs) such as CMIPCS to provide military recruiters, upon request, with the name, address, and telephone number of all secondary students unless the parent/legal guardian of a student (or the student if an adult) has advised the LEA in writing that he/she does not want the student's information disclosed without prior written consent. Such advisement by the parent/legal guardian (or adult student) must take place within 30 days of the notification of these rights, and may be done by checking one of the appropriate options below, signing this form and returning it to CMIPCS.

_____As the parent/legal guardian for the child named below, I request that CMIPCS not release the name, address, and telephone number of my child to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.

_____As an adult student (who has reached the age of 18), I request that CMIPCS not release my name, address, and telephone number to the Armed Services, military recruiters, service academies or military schools unless I separately consent to such release in writing.

_____	_____	_____
Student's Name Printed	**Signature of Parent/Legal Guardian or Student** (if an adult)	**Date**

Notice of Non-Discrimination *In accordance with state and federal laws, Creative Minds International PCS does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business.*

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CMI Technology Policy

Students agree to follow age-appropriate guidelines for appropriate technology use at CMI, such as:

- using electronic resources for educational purposes only;
- avoiding waste of resources, such as printer toner and paper;
- respecting intellectual property and copyright laws;
- protecting oneself and respecting others when accessing the internet;
- reporting any incidents of cyberbullying immediately;
- reporting any offensive materials or computer viruses immediately;
- acknowledging that any message or file saved on, sent from, accessed through, or received on CMI equipment may be inspected;
- keeping one's passwords private and respecting the privacy of others' passwords;
- taking care of the school's hardware, electronic systems, and network;
- protecting one's safety by not sharing any personal information online; and
- protecting oneself and the school's technology equipment by not viewing, sending, displaying, or downloading any illegal, inappropriate, or offensive materials.

Any questions regarding CMI's Instructional Technology program may be directed Andy Charrier at Andy.Charrier@creativemindspcs.org.

I understand and will abide by the Internet Use Agreement. I further understand that any violation of the regulations in the Agreement is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken and/or legal action may result.

Student Name _____ Parent Name _____

Date _____ Signature _____

Creative Minds International Public Charter School
Sherman Building, 3700 North Capitol St NW, Washington DC 20011
Phone (202)588-0370 Fax (202)588-0263

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Opt-In for Text Messages

Our school utilizes the School Messenger system to deliver text messages, straight to your mobile phone with important information about events, school closings, safety alerts and more. To comply with wireless carrier requirements and protect against unsolicited text messages, you must opt-in.

___ I consent to receive SMS text messages

___ I do not consent to receive SMS text messages

Nature Walking Field Trips
I give permission to have my child participate in Nature Walks on the AFRH grounds for the 2020-21 school year.

___ I consent

___ I do not consent

Student Name _____ Parent Name _____

Date _____ Signature _____

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Notification of Rights under FERPA

The Family Educational Rights and Privacy Act (FERPA) affords parents and students age 18 or older ("eligible students") certain rights with respect to the student's education records. Upon request, CMIPCS discloses education records without consent to officials of another school or school district in which a student seeks or intends to enroll, or is already enrolled if the disclosure is for purposes of the student's enrollment or transfer.

(1) The right to inspect and review the student's education records within 45 days of the day Creative Minds International Public Charter School (CMIPCS) receives a request for access. Parents or eligible students should submit to the school principal a written request that identifies the record(s) they wish to inspect. The school principal or other appropriate school official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

(2) The right to request amendment of the student's education records that the parent or eligible student believes are inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA. Parents or eligible students may write the school principal, clearly identify the part of the record they want changed, and specify why it should be changed. If CMIPCS decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

(3) The right to consent (in writing) to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. For example, FERPA authorizes disclosure without consent to school officials whom CMIPCS has determined to have legitimate educational interests. A school official is a person employed by CMIPCS as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person or company with whom CMIPCS has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); an official of another school system where a student seeks or intends to enroll, or where the student is already enrolled; or a parent, student or other volunteer serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

(4) The right to withhold disclosure of directory information. At its discretion, CMIPCS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without the consent of parents or eligible students in accordance with the provisions of District law and FERPA. Directory information includes:

A. Student Name
B. Student Address
C. Student Telephone Listing
D. Name of School Attending
E. Participation in Officially Recognized Activities and Sports
F. Weight and Height of Members of Athletic Teams
G. Diplomas and Awards Received
H. Student's Date and Place of Birth
I. Names of Schools Previously Attended
J. Dates of Attendance

Parents or eligible students may instruct CMIPCS to withhold any or all of the information identified above (i) by completing the attached "Release of Student Directory Information".

(5) The right to file a complaint with the U.S. Department of Education concerning alleged failures by CMIPCS to comply with the requirements of FERPA. The name and address of the office that administers FERPA are: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Ave. SW, Washington, DC 20202.

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Notification of Rights Under the Protection of Pupil Rights Amendment (PPRA)

This notice informs parents/guardians and eligible students (emancipated minors or those 18 or older) of their rights regarding the conduct of surveys, the collection and use of information for marketing purposes, and the conduct of certain physical exams. These rights are spelled out in the *Protection of Pupil Rights Amendment* (20 U.S.C. § 1232h; 34 CFR Part 98). The law and regulations require educational institutions, such as Creative Minds International Public Charter School (CMIPCS) to notify parents and eligible students of their right to—

1. *Consent* before students are required to submit to a survey that concerns one or more of the following protected areas ("protected information survey") if the survey is funded in whole or in part by a program of the U.S. Department of Education (USDE):

    - Political affiliations or beliefs of the student or student's parent;
    - Mental or psychological problems of the student or student's family;
    - Sexual behavior or attitudes;
    - Illegal, antisocial, self-incriminating, or demeaning behavior;
    - Critical appraisals of others with whom respondents have close family relationships;
    - Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
    - Religious practices, affiliations, or beliefs of the student or parents; and
    - Income, other than as required by law to determine program eligibility.

2. *Receive notice and an opportunity to opt a student out of*—

    - Any other protected information survey, regardless of funding;
    - Any nonemergency, invasive physical exam or screening required as a condition of attendance administered by the school or its agent and not necessary to protect the immediate health and safety of a student, except for hearing, vision, or scoliosis screening, or any physical exam or screening permitted or required under state law; and
    - Any activities involving collection, disclosure, or use of personal information collected from students for marketing or to sell or otherwise distribute the information to others. (This does not apply to the collection, disclosure, or use of personal information collected from students for the exclusive purpose of developing, evaluating, or providing educational products or services for, or to, students or educational institutions.)

3. *Receive notice* of a parent's right to inspect, upon request and before administration or usage of—

    - Protected information surveys of students and surveys created by a third party;
    - Instruments used to collect personal information from students for any of the above marketing, sales, or other distribution purposes; and
    - Instructional material used as part of the educational curriculum.

CMIPCS has developed and adopted policies regarding these rights, as well as arrangements to protect student privacy in the administration of protected surveys and the collection, disclosure, or use of personal information for marketing, sales, or other distribution purposes. The CMIPCS policies related to PPRA rights, can be accessed in the CMIPCS Student and Family Handbook 2019-20. In addition, parents/guardians and eligible students may also contact the school for CMIPCS policies related to PPRA rights. Parents/guardians and eligible students who believe their rights have been violated may file a complaint with the—
Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Ave, SW Washington, DC 20202-4605

Notice of Non-Discrimination *In accordance with state and federal laws, Creative Minds International PCS does not discriminate on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an interfamily offense, or place of residence or business.*

DC HEALTH Immunization Requirements for School Year 2019-2020

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

On the first day of school my student is:	By the start of SY19-20, my student should have received:[i]
2-3 years old	4 doses of Diphtheria/Tetanus/Pertussis (DTaP) 3 doses of Polio 1 dose of Varicella if no history of chickenpox [ii] 1 dose of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
4 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses Hepatitis B 2 doses Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
5-10 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A
11+ years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP)/Td 1 dose of Tdap 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A[iii] 1 dose of Meningococcal (Men ACWY)[iv] 2 or 3 doses of Human Papillomavirus Vaccine (HPV)[v]

[i] The number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's health suite personnel or health care provider for details.

[ii] All Varicella/chickenpox histories MUST be verified by a health care provider and documented with month and year of disease.

[iii] If born on or after 01/01/05.

[iv] Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

[v] Two doses if student receives first dose between ages 9 -14 (doses 6-12 months apart); 3 doses if student starts series on or after age 15.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form replaces all physical examination forms dated before April 1, 2015. The District of Columbia Universal Health Certificate (DC UHC) is required annually for children enrolled in Child Development Facilities, Head Start, and DC public, public charter, private and parochial schools.
Exception: The DC UHC does not replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DC UHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) recommendations for child and adolescent preventive health care from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.
General Instructions: Please use a black ball point pen when completing this form.
Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which your address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. In addition, please provide the name of the insurance company and the child's identification number in the space provided. Write the name of the child's licensed health practitioner/primary care provider (doctor or nurse practitioner). If your child does not have a particular licensed health practitioner who provides care, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**
Part 2: Child's Health History, Examination & Recommendations: (To be completed by the licensed health practitioner). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination conducted by a physician, or nurse practitioner (some nurse practitioners also use the Advanced Practice Registered Nurse or APRN credential), as per the AAP recommendations, and DC Official Code § 38-602(a). The date entered here must indicate the actual date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three (3) years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
  Body Mass Index (BMI): If the child is two (2) years of age or older, the BMI has to be calculated and recorded inclusive of percentile. BMI is a measurement calculated from a child's weight and height.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is **required for all children under six (6) years of age**. Also, in accordance with AAP recommendations, anemia screening is recommended for menstruating girls. Please record the blood level and indicate which test was performed by encircling HGB, HCT or both.
- **Vision and Hearing Screens:** Children should begin receiving regular objective vision screens at age three (3), and objective hearing screens at age four (4). If an objective screen cannot be completed, but there is cause for concern, provide an explanation and resolution in Part 2, Section A.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other 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 (Under Rx) for the concern. If there are NO/NONE "HEALTH CONCERNS", then check the **'NO" or "NONE"** box in each health screening area.
- **SPECIAL NOTE:** "Dental Exam" – The health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No", the child should be referred to a dental home. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that children begin visiting the dentist within six (6) months of the eruption of the first tooth or by 12 months of age, and every six (6) months thereafter. For children under three (3) years of age, a licensed health practitioner may provide fluoride varnish applications if a dental home has not yet been established. Fluoride varnish applications are not required for entrance to child care or school.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE".
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE".
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark
- "NONE".
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Medication Plan or Licensed Practitioner's Medication Authorization Order and attach it to the DC UHC.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing: • **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform a risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the* most recent *AAP RED BOOK, and* in accordance with DC Official Code § 38-602 (c) (1) *Examination Requirements* and *DCMR 29-325.3 (g) Public Welfare, Child Development Centers*. Current DC regulations require that all children attending a child development facility (CDF) or school undergo a comprehensive annual physical examination inclusive of a tuberculosis exposure risk assessment, which is documented on the DC UHC. A tuberculin skin test (TST) should only be conducted upon recognition of **high risk factors** for exposure to tuberculosis. For children who are assessed as **HIGH RISK OF EXPOSURE,** please conduct the TST and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and if the child is treated mark the "treated" box. **All positive TSTs of children younger than five (5) years of age must be reported to the DC T.B. Control Program on 202-698-4040.** If the child is assessed as having a low risk of exposure, mark **"low"** in the box**. Please note that universal tuberculin skin testing of children entering CDFs and schools is neither recommended nor required.**
• **LEAD EXPOSURE RISKS: Every child less than six years of age must be tested twice for lead, regardless of perceived exposure risk.** Please document both the "Date" and "Result" of the most recent lead test on the DC UHC. Please indicate if "Pending." "Pending" results will be **valid for two months from the date of testing** and will not cause a child to be excluded from school-related activities or programs. The **'***Certificate of Testing for Lead Poisoning'* may also serve as test documentation and is available on the DDOE website: http://ddoe.dc.gov/publication/lead-screening-guidelines. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead and Healthy Housing Program. For detailed instructions, call 202-654-6036/202-535-2624. Providers may fax results to secure fax: 202-535-2607.** Please include the name, address, and phone numbers of the licensed health practitioner and parent/guardian.
Part 4: Required Licensed Health Practitioner's (physician or nurse practitioner) Certification and Signature: Providers remember to print your name and use the office/clinic stamp. Licensed health practitioner please respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation; and the child has received age-appropriate screenings (in accordance with AAP recommendations and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.
Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the licensed health practitioner to share the health information on this form with the child's school, child care facility, camp, or appropriate DC Government agency.

Forms are available online at **www.doh.dc.gov**
Access public health insurance programs at **www.dhcf.dc.gov**You may contact the School Nurse through the main office at your child's school

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION

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

Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly the date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature, address, phone number and date. Vaccine doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day must be separated by a minimum of 28 days.

Students shall be immunized in accordance to D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 and the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Requirements – For immunization requirements for District of Columbia School and Child Care Facility attendance, consult the Department of Health Immunization Program website at https://immunization.doh.dc.gov/irswebapp/home.jsp.

Immunization requirements are subject to change.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pneumovax	PPSV or PPV23	Vaqta	Hep A
Adacel	Tdap	Fluarix	Flu (IIV)	Infanrix	DTaP	Prevnar	PCV or PCV7 or PCV13	Varivax	Varicella
Afluria	Flu (IIV)	FluLaval	Flu (IIV)	Kinrix	DTaP + IPV	ProQuad	MMR + Varicella		
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	Recombivax	Hep B		
Cervarix	HPV2	Fluvirin	Flu (IIV)	Menomune	MPSV or MPSV4	Rotarix	Rotavirus (RV1)		
Comvax	Hep B + Hib	Fluzone	Flu (IIV)	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Tripedia	DTaP		
Decavac	Td	Havrix	Hep A	Pentacel	DTaP + Hib + IPV	Twinrix	Hep A + Hep B		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviation	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenza* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name, address, phone number or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name, address, phone number or stamp date this section.

Meeting Your Child's Medication and Treatment Needs at School

Creative Minds International PCS (CMIPCS) wants to make sure your children are healthy and safe so they can achieve at the highest levels at school. CMIPCS partners with the DC Department of Health (DOH) and the School Nurse Program to ensure that students are able to stay healthy at school. If your child has diabetes, asthma, allergies, or other medical conditions, please follow these important steps below so we can make sure that your child's medication and treatment needs are met while at school.

Completing Medication Forms

Whenever possible, administer medications at home. If your child needs to take medication or requires medical treatment during school hours, please have your medical provider complete the appropriate forms – there's the Medication and Treatment Authorization Form, the Asthma Action Plan and the Action Plan for Anaphylaxis. If you have any questions about which form is needed for your child, please speak with your school's nurse. If your child needs a dietary accommodation, your provider should also complete the Dietary Accommodations Form. These forms are all available from your school's nurse.

Reviewing Medication Forms

After your provider completes the appropriate forms, please submit the forms to your school's nurse. Also, bring with you the medication that your child requires, with proper labels from the pharmacy. If your child requires a special treatment, bring in the equipment needed as well. The school nurse will review the completed forms and seek your permission to speak with your child's medical provider if the nurse needs to clarify anything on the forms.

Making Plans to Provide Medication, Treatment or Accommodations

Once the forms are reviewed, the school nurse will prepare an Individualized Health Plan, as needed, that details how your child's health condition will be managed at school. The school nurse is available to educate other school staff who will need to understand your child's unique medical needs during the school day. If a dietary accommodation is needed, the school nurse will share that completed form with your school food vendor's dietician who will prepare menus that meet your child's needs.

Administering Medication and Providing Treatments

When your child needs to receive medication or treatment, school staff will ensure that your child is released from class to go to the nurse's office where the school nurse will administer the medication or treatment. Sometimes the school's nurse is not at the assigned school due to a normal absence or to cover another school. When this occurs, the school will ensure other trained school staff are available to administer your child's medication. Each school is required to have three staff trained to administer medication to students, and two of these staff must be specially trained to manage diabetes. If your child requires a special treatment that the school nurse is unable to administer, the school nurse's supervisor will assign another nurse to come to your child's school to provide the treatment.

Field Trips

Your child's school will also ensure trained staff will be present on field trips with your child and during all school-sponsored extracurricular activities in which your child is a participant unless you choose to participate in the field trip or activity and agree to administer any required treatment yourself.

Questions?

If you have any questions about medication access during school hours, please do not hesitate to contact your school's nurse directly. All school health and wellness questions can be directed to Nurse Owens at 202-588-0370 x115 or at deowens@childrensnational.org.

Updated: 2019

HUMAN PAPILLOMAVIRUS INFORMATION

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no cure for HPV, but the problems it causes can be treated.

About 20 million people in the U.S. are infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 12,000 women get cervical cancer and 4,000 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against four major types of HPV. These include two types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls and boys 11-12 years of age, but may be given as early as age 9 years. It is important for girls and boys to get HPV vaccine before their first sexual contact-because they have not been exposed to HPV. The vaccine protects against some – but not all – types of HPV. However, if female or male is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that females and males with HPV get vaccinated. In addition, the HPV vaccine can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

The vaccine is also recommended for females 13-26 years of age and males 13-21 years of age (or to age 26 in some cases) who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a three-dose series:

- **1st Dose: Now**
- **2nd Dose: two months after Dose 1**
- **3rd Dose: six months after Dose 1**

People who have had a life-threatening allergic reaction to yeast, are pregnant, moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If additional information is needed, please contact your healthcare provider, the D.C. Department of Health Immunization Program at (202) 576-7130 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).