Shiloh Child Development Center

Providing More Than 50 Years of Service to Families

1507 Ninth Street, NW
Washington, DC 20001-3318
Phone: 202-387-2986 • Fax: 202-387-3969

Application Packet

A Program of

HENRY C. GREGORY III FAMILY LIFE CENTER FOUNDATION
Celebrating over 30 Years of Strengthening Families
1507 NINTH STREET, NW · WASHINGTON, DC 20001-3318 ·PH: (202) 735-0056 FX: (202) 387-3969
TAX ID: 52-1245163

naeyc Accredited

Shiloh Child Development Center
Parent Checklist

The following items are required by all students:

Uniforms: White Tops and Blue Bottoms

Complete Emergency Change of Clothes including: Pants, shirt, socks, underwear, pull ups for 2 year olds (must open on the sides)

Bed Covering: Fitted Bottom Sheet, Flat Sheet/Blanket – Note: All bed covers must be taken home and washed every Friday. All sheets must be crib sized sheets.

Personal Items: A box of tissues, A box of wipes, Toothbrush, Toothpaste

Safety Items: No hair bead allowed in the hair. No sandals allowed – closed toe shoes only

General Reminders:

Breakfast is served from 8:00am – 9:00am

Our doors open at 7:00am and close at 6:00pm

Late Fees of $2 per minute will be paid by parents for pick-ups after 6:00pm. Fees are expected at the time of pickup. Failure to pay the late fee may result in the suspension of your child. Children are not allowed to come into the Center after 9:30am.

All Parents must have a valid and working contact telephone number on file at all times. We must have an emergency contact number in case you are not available.

Absences:
All children participating in the Child Care Subsidy Program are only allowed five unexcused absences per month. After the fifth unexcused absence, the child will be automatically terminated from the program. Excused absenses are granted with a doctor's note or WIC note.

Co-Payments:

Voucher program Co-payments must be paid on the date mutually agreed upon by the parent and director of the Shiloh CDC. Prompt payments are expected.

Private paying parents must pay for child care on the date mutually agreed upon by the parents and director of the Shiloh CDC. Prompt payments are expected.

C&RCFD 045 REV 07/04

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

PLEASE PRINT OR TYPE

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
(Last, First, M.I.)

Date of Birth: _____ Home # _____

Home Address: _____
(Number, Street, Apt. #, State, ZIP)

Father: _____ Cell # _____
(Last, First, M.I.) Home # _____ Business # _____

Home Address: _____
(Number, Street, Apt. #, State, ZIP)

Business Address: _____
(Number, Street, Apt. #, State, ZIP)

Mother: _____ Cell # _____
(Last, First, M.I.) Home # _____ Business # _____

Home Address: _____
(Number, Street, Apt. #, State, ZIP)

Business Address: _____
(Number, Street, Apt. #, State, ZIP)

Relative or Guardian: _____ Cell # _____
(Last, First, M.I.) Home # _____ Business # _____

Home Address: _____
(Number, Street, Apt. #, State, ZIP)

Business Address: _____
(Number, Street, Apt. #, State, ZIP)

Person to be contacted in case of an emergency:

_____ Relationship to child: _____
(Last, First, M.I.)

Address: _____
(Number, Street, Apt. #, State, ZIP) Phone #

Designated individual authorized to receive child at end of session:

_____
(Last, First, M.I.)

_____
(Last, First, M.I.)

_____
(Last, First, M.I.)

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

Date of Withdrawal: _____ **Reason:** _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

C&RCFD 046 REV 07/04

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

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: _____ (M.D./N.P.) Telephone No: _____ (Area Code)

Address: _____

I give permission to _____ (Name of Facility or Caretaker), located at

_____, 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

PLEASE RETAIN A COPY FOR YOUR RECORDS

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐M ☐F	Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____	
Parent or Guardian Name:	Telephone: ☐Home ☐Cell ☐Work	Home Address:			Ward:
Emergency Contact Person:	Emergency Number: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)			Zip code:
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other_____	Primary Care Provider (PCP):			

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

Health Provider: Form must be fully completed.

DATE OF HEALTH EXAM:	WT ☐LBS ☐KG	HT ☐IN ☐CM	BP: (>3 yrs) ☐NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐Glasses ☐Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

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

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If TST Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

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

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

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

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

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

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

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

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

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

Reason:_____

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

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

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

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

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

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

CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender: ☐ M ☐ F	School or Child Care facility:
Parent/Guardian Name	Telephone1: ☐ Home ☐ Cell ☐ Work	Home Address:		Ward
Emergency Contact:	Telephone2: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zip code:
Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____				
Primary Care Provider (Medical):	Dentist/Dental Provider:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants

X - Missing teeth

● Restoration

| | Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y N	
2. Plaque and/or Calculus	Y N	
3. Abnormal Gingival Attachments	Y N	
4. Malocclusion	Y N	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to		
DDS/DMD Signature	Print Name	Date
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	Date

OSSE

The Child and Adult Care Food Program

Medical Substitution Form

Statement for Special Diet Prescription

The following child is a participant in the United States Department of Agriculture (USDA) Child Care component of the CACFP. USDA regulation 7CFR Part 226.20(h) requires substitution or modifications in program meals for children with special dietary needs or disabilities restrict their diets. A child with a disability must be supplied substitutions for foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

Part 1: To be completed by Parent/Caregiver

Child's Name:	Date of Birth: / Gender *(circle)*: M F
Name of School/Center/Program/Provider:	Grade Level/Classroom *(if applicable)*:
Name of Caregiver/Guardian	In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act I hereby authorize (physician/medical authority name: _____) to release such protected health information as is necessary for the specific purpose of Special Diet information to (Program Name:_____) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on (Date:_____). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian or authorized representative of the child listed on this document and has the legal authority to sign on behalf of that child. Parent/Guardian Signature:_____ Date:_____
Home Phone: / Work Phone:	
Street Address:	
City, State, Zip Code:	

Part 2: To be completed by Physician/Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

Does the child have a disability? Yes_____ No_____ If Yes, please describe the major life activities affected by the disability.	Does the child have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.
If the child is not disabled, does he/she have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.	Does the child require emergency medication be administered? Yes_____ No_____ If yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by a Recognized Medical Authority

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

List any dietary restrictions or special diet:

List any food allergies or food intolerances:

List foods to be substituted (mandatory):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number:		Office Stamp
Physician's/Medical Authority Signature		Date

Part 4: Parent or Guardian Signature

Parent or Guardian Signature		Date

Part 5: Program Official Signature

Program Official Signature		Date

*Please have parent/guardian review form annually and initial/date if no changes are required.
Any changes require submission of a new form signed by the Physician/Medical Authority.

CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*School or Child Care facility:*
Parent/Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*		*Ward*
Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*		*Zip code:*

Race/Ethnicity: ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____

Primary Care Provider (Medical):	*Dentist/Dental Provider:*	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* _____

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants

X - Missing teeth

● Restoration

|| Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y N	
2. Plaque and/or Calculus	Y N	
3. Abnormal Gingival Attachments	Y N	
4. Malocclusion	Y N	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to _____

DDS/DMD Signature	*Print Name*	*Date*
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	*Date*

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that all children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

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

Part 1: Child's Personal Information
Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.
Please use key to document all findings for each tooth. An '**X**' signifies a missing tooth (teeth) with no replacement; non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.
- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. Final Evaluation/Required Dental Provider Signature; Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete refer patient for follow up care. Dentist must **sign, date, and provide required information.**

Part 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date
The parent or guardian must print, sign, and date this part. By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

Medication Authorization Form

Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.1; "No Child Development Facility may provide medicine or treatment, with the exception of emergency first aid, to any child, unless the Facility has obtained a written medical order or prescription from the child's licensed health care practitioner and the written consent of the child's parent (s) or guardian (s)."
Pursuant to Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 377.4; "The Facility shall maintain a medication log, on a form approved by the Director, on which the Facility shall record the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication, each time any medication is administered to a child."

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

I do hereby give permission to _____ (Name of Facility) to administer the below noted prescribed medication to my child _____ born on _____.

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

_____ _____
Signature of Physician Date

_____ _____
Signature of Parent/Guardian Date

Part II: To be completed by the Center Director or designee:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE RETAIN A COPY FOR YOUR FILE

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

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Tuition Pay Rates
Effective 10/1/2014

1. **Parents who have received DHS Vouchers will be responsible for the agreed upon payment stated on the voucher.**

2. **Private Pay Rates include the following:**

Age	Daily Rate	Weekly Rate	Monthly Rate
Toddler (2.0 to 2.6)	$58.50	$292.50	$1,170.00
Preschool (2.7 to 4)	$42.00	$210.00	$840.00

School Age – 4 to 12 Years Old

	Daily Rate	Weekly Rate	Monthly Rate
Before and After	$19.20	$96.00	$384.00
Before or After	$14.40	$72.00	$288.00
Full Day (Drop-in, Vacation, Summer Program	$32.00	$160.00	$640.00

Shiloh Child Development Center

Providing 55 Years of Service to Families

Parent/Guardian Contact Information

PLEASE PRINT CLEARLY

Parent(s)/Guardian(s):	First Name: Last Name:
Address:	
Phone:	Home:_____ Work:_____ Cell: _____
Email Address (home): **Email Address (work):**	_____ _____
Child/Children/Age:	1. _____Age_____ 2. _____Age_____ 3. _____Age_____ 4. _____Age_____
Payment and/or Co-payment per month	$_____

Name of Previous Child Development Center:

_____

Address: _____

_____

Phone: _____

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Washington, DC 20001-3318
Phone: 202-387-2986 • Fax: 202-387-3969

Dear Parent/Guardian,

Shiloh Child Development is excited to now offer free developmental screening for all students attending the Center. The developmental tool that will be used to screen your child is called the Ages & Stages Questionnaire®; it will help our teachers identify your child's strengths and the areas in which he/she may need additional support. The teachers received professional training during the summer to be skilled at performing the screening. The results of the screening will be shared with you. These are the areas covered by the screening:

Area of Development	Examples
Communication	talking in sentences, speaking clearly, understanding directions
Gross Motor	climbing, jumping, walking up stairs, throwing a ball
Fine Motor	writing, drawing, using scissors, using buttons
Cognitive	solving problems, knowing colors, understanding numbers
Personal-Social	washing, getting dressed, eating

Your child's teacher will complete the developmental portion of the screening. In addition, you will complete a few overall questions about your child (Please see attached.)

Your involvement in the process is important. The screening can only take place with your permission; therefore, please make sure to sign the attached consent to screen.

If you have any questions, please do not hesitate to contact me by email at: isabelle.mack@flcfoundation.org or by phone at 202-735-0056.

Classroom Screening Consent Form for Shiloh Child Development Center

Child/Children		Date of Birth
Parent/Guardian		Relationship to Child

Consent to Conduct a Developmental Screening:

I, _____ give permission for Shiloh Child Development Center to
(Parent's Name)

conduct a developmental screening of my child _____
(Child's Name)

Parent/Guardian Signature_____ Date: _____

PLEASE RETURN THIS FORM TO Ms. Camelia Miller

Parent/Guardian Questionnaire

Child's Name: _____

Please answer YES or NO and explain when appropriate

1. Do you think your child hears well? If no, please explain:

2. Do you think your child talks like other children his age? If no, please explain:

3. Can you understand most of what your child says?
If no, please explain:

4. Can other people understand most of what your child says? If no, please explain:

5. Do you think your child walks, runs, and climbs like other toddlers his age?
If no, please explain:

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

7. Do you have any concerns about your child's vision? If yes, explain:

8. Has your child had any medical problems in the last several months? If yes, explain:

9. Do you have any concerns about your child's behavior? If yes, explain:

10. Does anything about your child worry you? If yes, explain:

PERSONAL – SOCIAL:

Please answer YES, NO, or SOMETIMES

Does your child serve himself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl? (**For office use only** 48 months #1, 54 months #4, 60 months #1)

Does your child brush her teeth by putting toothpaste on the toothbrush and brush all of her teeth by herself (you may need to check and re-brush your child's teeth)?
(For office use only 48 months #5, 54 months # 3)

Does your child dress and undress by himself (except for snaps, buttons, or zippers)? (**For office use only** 48 months # 6)

Does your child dress and undress by himself (including buttoning medium size buttons, or zipping front zippers)? (**For office use only** 54 months # 6, 60 months #4

Please complete and return to your child's teacher

Shiloh Child Development Center

Providing More Than 50 Years of Service to Families

1507 Ninth Street, NW
Washington, DC 20001-3318
Phone: 202-387-2986 • Fax: 202-387-3969

Parental Consents

Emergency Permission:
You have my/our permission, in the event of an emergency and in case we are unavailable, to authorize any physician, nurse practitioner or medical personnel to examine, interview, test and if necessary, treat my child(ren)_____

_____

as they may deem advisable.

Parent/Legal guardian
name_____Date_____

Parent/Legal guardian
Signature_____Date_____

Student
Allergies_____
_____
_____

Parent/Guardian Release of Liability and Acknowledgement of Code of Conduct:

I hereby state that (student's name) _____
_____
_____
has my permission to participate in, and be transported to and from, all educational field trips and activities of the FLCF programs (CDC, STEM, Music, Tennis, etc.). My child is in good mental and physical health condition to participate in the activities provided by **FLCF** including but not limited to all aspects of the NASA fitness and/or other physical activities during the year. I acknowledge and understand that participation in some activities include risks and the possibility of serious injury. I hereby agree to hold harmless and release the **FLCF, its board of trustees, employees, agents and volunteers and/or the Shiloh Baptist Church trustees and staff** from any and all liability arising out of my child's participation in any event sponsored or sanctioned by **FLCF** and/or travel to and from such event or activities. I hereby agree to take no legal action against FLCF**,** its board of trustees, employees, agents and

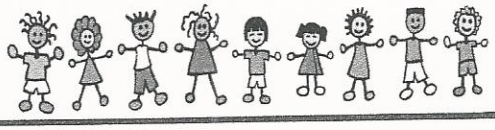
volunteers and/or the Shiloh Baptist Church trustees and staff because of any accident or incident involving my child's participation in activities sponsored by FLCF.

I understand that **FLCF** has the right to deny admittance to any student not meeting the standards of the program as it sees fit. I also agree not to hold FLCF, its board of trustees, employees, agents and volunteers and/or the Shiloh Baptist Church trustees and staff responsible in the event that my son/daughter/child engages in inappropriate conduct as solely determined by FLCF (including, but not limited to disruptive or volatile behavior in or out of any activity, etc.) or becomes involved in any activity or with any persons not associated with **FLCF** or its scheduled program and that **FLCF** has the right to send him/her home for such conduct. I further attest that the information contained in this application is correct to the best of my knowledge. In addition, I have agreed to the policy and fee statement and agree to comply.

I hereby give permission to **Henry C. Gregory III Family Life Center Foundation (FLCF)** to photograph and/or videotape the student for educational or promotional purposes. _____ (Initial)

Parent/Guardian
Signature_____Date_____

Shiloh Child Development Center



Providing 55 Years of Service to Families

1507 Ninth Street, NW
Washington, DC 20001-3318
Phone: 202-387-2986 • Fax: 202-387-3969

February 27, 2014

Dear Parents:

Some time ago the Shiloh Child Development revised its payment policy to only accept checks and money orders left in the payment window in front of Ms. Kinard's office. We are reiterating that policy: **under no circumstances** should you leave cash in an envelope in that window. The window clearly states "checks and money orders only."

Your other payment options for cash payments are:

- Bring cash to the 2nd floor to Ms. Eddie Witten or Ms. Isabelle Mack
- Pay with your debit and/or credit card by contacting Ms. Mack (office: 202/735-0056 or cell: 202/255-8468)

Sincerely,

Isabelle G. Mack, MPA
Executive Director
Henry C. Gregory III Family Life Center Foundation
1507 – 9th Street, NW
Washington, DC 20001-3318
Ph: 202/735-0056 or 202/232-4201
Fx: 202/387-3969
isabelle.mack@flcfoundation.org

The HCGIII Family Life Center Foundation is a nonprofit organization designated by the IRS as a 501(c)(3). All donations are fully deductible to the extent provided by law.