intown
PLAYGROUP
1334 29th Street NW ♥ Washington, DC 20007
intownplaygroup@gmail.com

April 5, 2018

Dear Intown Families,

Welcome new families and welcome back returning families. Attached are the forms that must be completed for your child and parent or caregiver prior to starting summer camp and school. Your child cannot attend Intown with out these forms. Please scan and email all completed forms to intownregistrar@gmail.com. If you prefer to mail or drop off your forms, you can do so at Intown 1334 29th St, NW, Washington, DC 20007. If your child is attending summer camp, forms are due by **May 31, 2018**. If your child is starting in the Fall, forms are due by **August 1, 2018**. If you have any questions, please email the above email.

Thank you,

Intown Registrar

CHILD NECESSARY FORMS:

- Emergency Information and Permission, Photo Release, Emergency Procedures, Waiver and Release of Liability, and Parent Handbook ("Intown Form")
- Authorization for Child's Emergency Medical Treatment
- Registration Record for Child Receiving Care Away from Home
- District of Columbia Universal Health Certificate (for child)
- Travel and Activity Form – please check blanket permission and put N/A for trips in a van and field trips away from facility

ADULT CAREGIVER/PARENT NECESSARY FORM

- Provider Health Certificate (for ADULTS ONLY, parents and caregivers that will attend Intown with child)

intown
PLAYGROUP
1334 29th Street NW ♥ Washington, DC 20007
202-337-2720 ♥ intown@intownplaygroup.org

Name of Child: _____ (hereinafter "Child")

Evacuation Emergency Contacts

Home Address: _____

Parent 1: Name: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Parent 2: Name: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Caregiver:_____ Caregiver's Cell Phone:_____

List authorized individuals that can pick your child up from school:

_____ _____ _____

Emergency Information and Permission

Regarding my Child, I grant permission to Intown Playgroup and its staff to take him/her to the park and/or for walks within a five-block radius of the school, provided he/she is under the direct supervision of any teacher or duty person affiliated with Intown Playgroup. INTIALS_____

I grant permission for my Child to ride in the car of any parent or teacher affiliated with Intown Playgroup for emergency purposes only. INTIALS _____

List FOUR Intown parents that can take your child into their home:

1. _____ 2. _____

3. _____ 4. _____

Does your Child have any known allergies? _____

Any additional information Intown Playgroup should know about the health of your Child?

_____

Intown Playgroup Photo Release

I hereby grant permission for images of my Child at Intown Playgroup to be used by the school inside school premises, on Intown password-protected websites for parents and alumni, and for photobooks and similar materials for current Intown parents and children. This permission includes likenesses of my Child and our family members, and any schoolwork. **If images of your Child are to appear in more public forums such as the school website, slideshows, and brochures, additional permission will be requested**

_____ Yes, I confirm that I have read and understand the above, and agree for my Child's images and schoolwork to be used.

_____ No, I do not wish to have my Child's images and schoolwork used.

INITIALS _____

intown
PLAYGROUP
1334 29th Street NW ♥ Washington, DC 20007
202-337-2720 ♥ intown@intownplaygroup.org

Name of Child: _____ (hereinafter "Child")

Emergency Procedures

In the event of an emergency in the Washington, DC area, the following procedures will be in place for the families of Intown:

1). Please pick up your Child or leave Intown immediately if you are already at the school. Do not wait for a phone call. Assume that we cannot reach you. If possible, there will be a message on the Intown voicemail stating our plan of action.
2). If you are unable to pick up your Child personally, you must send someone authorized to do so.
3). If you are unable to arrange for an authorized person to pick up your Child, assume that the Intown staff will stay in the locked school for approximately thirty minutes unless the staff determines it is not safe or prudent to do so.
4). In the event that your Child is not picked up within thirty minutes, your Child will be released to a member of the Intown parent body in the area, with information on their location posted on the door of the school.
5). If there is a biological or chemical attack, your Child will be locked inside the school and you are to come get them only when public safety officials for the city of DC have given the OK to be outside. We will not open the doors until we have received an official OK.
6). In the event that the emergency directly affects the school grounds (ie, bomb threat, fire, etc), we will relocate to Christ Church, 3116 O St. NW, 202-333-6677 INTIALS _____

Authorization to Dispense Potassium Iodine

If an emergency situation occurs and Intown Playgroup administrators determine it is prudent, I give permission to give my child Potassium Iodine 32mg. This is the dosage recommended by CDC guidelines to block thyroid uptake in the event of a radiation emergency for children 1 month to 3 years. INTIALS_____

Waiver and Release from Liability

I, _____(print parent's name), grant permission for my Child to participate in all activities of Intown Playgroup. I understand that Intown Playgroup and/or any of the staff or members of the Board of Directors cannot be held liable for accidents that may occur under their supervision. I assume all risks and hazards incidental to such participation, including risk of injury to my Child, and do hereby release and waive on my Child's behalf and on the behalf of myself and other relatives of my Child any and all claims relating to such participation of activities designed by Intown Playgroup and/or any of the staff or members of the Board of Directors. INTIALS _____

Parent Handbook

I have received and read the Intown Playgroup 2018-2019 Parent Handbook. I agree to abide by the guidelines, policies, rules, and other obligations set forth in the Intown Playgroup 2018-2019 Parent Handbook.
INTIALS _____

I have read, understand, and agree to the Emergency Information and Permission, Photo Release, Emergency Procedures, Waiver and Release of Liability, and Parent Handbook sections, initialed above.

PARENT SIGNATURE: _____ DATE: _____

PARENT NAME PRINTED: _____

intown
PLAYGROUP
1334 29th Street NW ♥ Washington, DC 20007
202-337-2720 ♥ intown@intownplaygroup.org

Name of Child: _____

Cooping Schedule

Intown is a cooperative playgroup and parents play an essential role in our daily routine. Parents are required to coop every 4 weeks. These are preference only and we will try to accommodate, but not guaranteed.

Please mark the days of the week you CANNOT coop:
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Intown has fun picnics and in school parties through out the year. Parents will be assigned to 1-2 events to help coordinate. These are fun traditions and parents are essential to each event.

Please mark the parties you CANNOT be assigned:
Fall Picnic (September) _____
Halloween (October 31st) _____
Winter Holiday Party (December) _____
Valentine's Day (February 14th) _____
Spring Picnic (April) _____
Graduation (May) _____

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

C&RCFD 045 REV 07/04

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

PLEASE PRINT OR TYPE

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

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

Date of Birth: _____ Home # _____

Home Address: _____
Number Street Apt. # State ZIP

Father: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Mother: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency:

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

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

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

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

PLEASE RETAIN A COPY FOR YOUR RECORDS

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

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 **MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002**

PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

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

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

_____give my permission to
Name of Child

_____for my child to participate in the following activities:

Trips in the van/automobile (facility or parent -owned)

_____
Explain planned activity — where and when

Field trips away from the facility

_____
Explain planned activity — where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,
☐ I will allow my child to play outside the fenced area; or _____
☐ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

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

C&RCFD 044 REV 07/04

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

CHILD & RESIDENTIAL
CARE FACILITIES DIVISION

Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:

825 North Capitol
Street, NE
Second Floor
Washington, DC 20002

ADULT'S ONLY

PROVIDER HEALTH CERTIFICATE

Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Telephone No: _____

Address: _____

I have examined the above-named person and certify that he/she is:

- Free from disease in communicable form.
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ PPD ☐ Chest X-Ray

Date: _____ Result: _____ _____
Signature of Recorder

Other: _____

_____

_____

_____ MD/NP Date of Examination: _____
Signature of Examining Physician/Nurse Practitioner

_____ Telephone No.: _____
Address (Area Code)

PLEASE RETAIN A COPY FOR YOUR RECORDS

INTOWN CHILD'S NAME:_____