For Office Use Only
Submission Date and Time
____/____/____ _____

EXTENDED LEARNING PROGRAM

Student Enrolment Packet

Student Name: _____ Grade:_____ Campus: _____

In which *Rocket Booster!* program are you enrolling this Rocketeer?

- ☐ Full Before and After Care ($350 per month per student)
- ☐ Before Care Only ($100 per month per student)
- ☐ After Care Only ($296 per month per student)
- ☐ Early Release Wednesday After Care Only ($100 per month per student)

All of the forms included in this packet must be submitted for every Rocketeer who is being enrolled in *Rocket Booster!*

- ☐ Rocket Booster! Handbook Confirmation Form
- ☐ Rocketship Public Schools Media Release Form
- ☐ Registration Record for Child Receiving Care Away From Home
- ☐ Authorization for Child's Emergency Medical Treatment
- ☐ Blanket Travel and Activity Authorization
  - **Note:** Families will be notified in advance of any offsite activities.
- ☐ DC Health Universal Health Certificate and Oral Health Assessment
  - **Note:** The Universal Health Certificate must contain your child's up-to-date immunization record.
- ☐ DC Health Medication and Medical Procedure Treatment Plan (if applicable)
  - **Note:** The DC Health forms must be submitted for Rocketship enrollment. If up-to-date forms have already been submitted at your Rocketeer's campus, please indicate that within this packet and Rocket Booster! will obtain the form from the main office.

ROCKETSHIP PUBLIC SCHOOLS

Rocket Booster!

Rocketship's Extended Learning Program

2021 - 2022 SCHOOL YEAR HANDBOOK CONFIRMATION FORM

Please clearly print your name and sign the following form as confirmation that you have fully read and understood the contents of the *Rocket Booster!* Extended Learning Family Handbook.

I,_____, understand the information and agree to the rules and procedures presented in the 2021-2022 *Rocket Booster!* Family Handbook.

Rocketeer (s)' names (please print first/last name[s] clearly)	Campus Attended

Parent/Guardian Signature: _____

Parent/ Guardian Printed Name: _____

Date: _____

ROCKETSHIP
PUBLIC SCHOOLS

Media Release Form

Rocketship Public Schools is proud of the many accomplishments of our students and staff. Often, such accomplishments draw the attention of RPS partners, newspapers, television stations, or other media who visit our schools to photograph, videotape, record, and/or interview students and staff during various activities. In addition, we often use pictures of our students in Rocketship Public Schools publications and websites. Our education partners may also want to use student pictures and recordings for similar educational and promotional purposes. In furtherance of our goal to develop exceptional educators, we may invite educational partners (e.g., teacher credentialing organizations) to attend classroom sessions and share classroom photos and videos with these organizations to support our educators' professional development.

For your child's privacy, we must know whether or not you want your child to be photographed, videotaped, or interviewed for the purposes described above. .

▢ **Yes, I DO give permission** for my child to be photographed, videotaped, or interviewed by the news and/or media for any reason and for Rocketship Public Schools to use my child's photograph, name, words and work product in school and Rocketship Public Schools publications, websites, and other marketing materials. or Rocketship Public Schools and its licensees (e.g., third-party educational support organizations and partners)—collectively "Rocketship".-Further, I authorize Rocketship to record my child's likeness and/or voice with still photography, film, videotape, or digital recording ("Recordings") and to edit such Recordings, and to use, reproduce, display, and/or distribute, and/or to make derivative works from any of the Recordings or my child's work product for educational and promotional purposes, in perpetuity. I understand and agree that use of such Recordings and work products will be without any compensation to me or my child. I understand and agree that Rocketship may display or otherwise use my child's first and last name in conjunction with its use of the Recordings and/or my child's work product. I understand and agree that Rocketship and/or its authorized representatives shall have the exclusive right, title, and interest, including copyright, in the Recordings.

▢ **No, I DO NOT give permission** for my child to be photographed, videotaped, or interviewed as described above. Nor do I give my permission for Rocketship Public Schools to use my child's Recordings for the purposes described above.

I / We the undersigned declare under penalty of perjury that we are the parents or legal guardians of the above-named student and grant the above authorizations.

Parent/Guardian Signature: _____ **Date:**_____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

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

Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # ✔ _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # ✔ _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

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

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

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

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

TO BE COMPLETED BY THE FACILITY

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

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)

If my child _____, born on _____/_____/_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ❑ DC ❑MD ❑VA

Child's known Allergies or Physical Conditions: _____
_____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

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

Place in child's folder/record.

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

TRAVEL AND ACTIVITY AUTHORIZATION

❑ Special one time permission for this activity only ■ Blanket permission for all given activities

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

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

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

_____
Explain planned activity - where and when

Field trips away from the facility

Off campus activities associated with Rocket Booster! Extended Learning Program
_____
Explain planned activity - where and when

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

In addition, if the facility has planned activities outside the fenced area of the facility,

❑ I will allow my child to play outside the fenced area; or

❑ I will not allow my child to play outside the fenced area.

This authorization is valid from ✔/✔/21 to 06/30/22

_____ _____
Parent/Guardian Signature Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.

EXTENDED LEARNING PROGRAM

Student Name: _____ Grade:_____ Campus: _____

The DC Health forms listed below must be submitted for Rocketship enrollment. If up-to-date forms have already been submitted at your Rocketeer's campus, please indicate that below and *Rocket Booster!* will obtain the form from the main office.

The Universal Health Certificate and Oral Health Assessment expire after one calendar year. Updated forms must be submitted before the expiration date in order for your Rocketter to continue attending *Rocket Booster!*

Example: If your Rocketeer's last physical or dentist appointment was on April 20, 2021, you must submit a new Health Certificate or Oral Health Assessment by April 20, 2022. Your Rocketeer will be unable to attend *Rocket Booster!* until an updated form is submitted.

- ☐ DC Health Universal Health Certificate
  - **Date Completed: ____/____/____**
  - **Note:** The Universal Health Certificate must contain your child's up-to-date immunization record.
- ☐ Oral Health Assessment
  - **Date Completed: ____/____/____**
- ☐ DC Health Medication and Medical Procedure Treatment Plan (if applicable)

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

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/Guardian Name:	**Parent/Guardian 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
- ☐ Developmental
- ☐ 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.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide 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): Verified by: _____ (name & title)				
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				
Other	1	2	3	4	5	6	7

☐ 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

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

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.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____
_____

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:

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	PreK3	PreK4	K	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 **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 **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

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:**