



July 2011

Dear E-T ECC Family,

We are happily anticipating your return on Tuesday, September 6th. We are currently preparing for this fall and have a packet of paperwork and forms for you, your child's physician, and dentist (*for children over 3 only*) to complete and return to us. Please notify us during the year if any information changes—including contact information (*e.g. address, phone, e-mail, emergency contacts*) carpool information, and medical information (*e.g. allergies, health issues, etc.*)

The paperwork and forms that you need for school follow this letter. Please complete and return everything to our office in one complete package. We will accept the package as soon as it has been completed, but everything must be returned to our office no later than Tuesday, August 31st. If you need an extension on your medical forms, please call the office at 202-895-6334. The forms include:

- Child Emergency Contact Information School Year 2011-2012
- DC Department of Health Authorization for Child's Emergency Medical Treatment
- *DC Universal Health Certificate (due date for new families is August 31; due date for currently enrolled families will be sent under separate cover)*
- Authorization and Release of Liability (*for students with food and/or bee sting allergies that may result in anaphylaxis*)
- Allergy Addendum School Year 2011-2012
- Food Allergy Action Plan
- *DC Oral Health (Dental Provider-for children over 3 only) (due date for new families is August 31; due date for currently enrolled families will be sent under separate cover)*
- Physician Medical Form
- Student medical Checklist School Year 2011-2012

- Travel and Activity Authorization (*Required by DC*)
- Consent and Liability Waiver
- Field Trip Permission Form
- Carpool Permission Form
- WHC E-T ECC Enrollment Agreement
- WHC E-T ECC Enrollment Agreement (*copy for files*)
- Fee and Payment Schedule
- E-T ECC Calendar 2011-2012
- Acknowledgement of Parent Handbook (*you will receive and sign this at your "Meet & Greet" with your teacher. You will receive your school handbook at that time*)
- Challah Order Form: Fall Semester 2011
- Pizza Party RSVP Form

Our school strives to be green. Rather than mail or send home many flyers and forms in backpacks, we e-mail information, flyers, newsletters, calendars and forms you will need. Of course, if you every have problems downloading or printing our forms or documents, we always keep a few hard copies in our office. Simply stop by and we will be happy to provide you with what you need.

Later this summer we will send you an email with information about your child's class and what you need to know before the school year begins. Our emails come from Lauren Lieberman (llieberman@whctemple.org) so please add us to your address book so our emails don't end up in your spam filter.

Please know that if you ever have any questions or concerns, our staff is here to assist you. You can reach us at 202-895-6334 or llieberman@whctemple.org. If you are a new family, we look forward to getting to know you and your child. If you are a returning family, we can't wait to see you soon!

Sincerely,

Nancy Cook

Nancy Cook

Director

Edlavitch-Tyser Early Childhood Center

Washington Hebrew Congregation



Washington Hebrew Congregation
Early Childhood Centers & Primary School

Child Emergency Contact Information

School Year 2011-2012

Child's Name: _____

Address: _____

PLEASE PROVIDE CONTACT INFORMATION FOR EACH PARENT/GUARDIAN PLUS ONE OTHER INDIVIDUAL WITH WHOM WE MAY CONSULT AND TO WHOM WE MAY RELEASE YOUR CHILD IN THE EVENT OF AN EMERGENCY:

Parent/Guardian #1 _____ Relationship _____

Home Phone _____

Business Phone _____

Mobile Phone _____

Email Address _____

Parent/Guardian #2 _____ Relationship _____

Home Phone _____

Business Phone _____

Mobile Phone _____

Email Address _____

Emergency Contact _____ Relationship _____

Home Phone _____

Business Phone _____

Mobile Phone _____

Name of physician or clinic _____ Phone _____

Name of dentist _____ Phone _____

Hospital Preference _____

Recurring illnesses (asthma, allergies, etc.) _____

Dietary restrictions (Kashrut, allergies, etc.) _____

In the event of an emergency, after an effort has been made to contact parents/guardians or those listed on this or any emergency form provided by WHC, I hereby give permission to the physician selected by the WHC, or the WHC teachers, administrators, staff members, agents or other representatives (collectively, "WHC representatives") to summon an ambulance, hospitalize, secure proper treatment for and/or order injection, anesthesia or surgery for my child; I authorize WHC and WHC representatives to take any other action a physician deems necessary or appropriate in the particular circumstances. I hereby release WHC and all WHC officers, directors, and other WHC representatives from all liability or responsibility or responsibility in connection therewith. I hereby agree to indemnify any and all of the WHC representatives from and against any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to, reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representatives' good faith effort to obtain medical assistance for my child.

Parent's Name: _____

Parent's Signature: _____ Date: _____

To be completed by E-T ECC: Date of Admissions: _____ Date of Withdrawal: _____ Reason: _____



PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

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

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

Hospital: _____

Address: _____

or:

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

Address: _____

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

_____, to take my child for treatment.

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

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: DC MD VA

Child's Known Allergies or Health Conditions: Yes No
(If yes, explain here: _____

Home Address: _____
Street City/State Zip Code

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

Signature: _____

Relationship to Child: _____

Date: _____
month/day/year



DISTRICT OF COLUMBIA 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: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____
Parent or Guardian Name:	Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> 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 <input type="checkbox"/> LBS <input type="checkbox"/> KG	HT <input type="checkbox"/> IN <input type="checkbox"/> CM	BP: _____ (^{>3 yrs}) <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index (BMI) _____ (^{>2 yrs}) % _____
HGB / HCT <i>(Required for Head Start)</i>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred	Hearing Screening Pass _____ Fail _____ <input type="checkbox"/> Referred	
HEALTH CONCERNS:	REFERRED or TREATED	HEALTH CONCERNS:		REFERRED or TREATED
Asthma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Language/Speech <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Seizure <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Development/ Behavioral <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Other _____ <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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	<input type="checkbox"/> HIGH→ <input type="checkbox"/> LOW	Tuberculin Skin Test (TST) DATE:	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	If TST Positive <input type="checkbox"/> CXR NEGATIVE <input type="checkbox"/> CXR POSITIVE <input type="checkbox"/> TREATED	Health Provider: POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	<input type="checkbox"/> YES→ <input type="checkbox"/> 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
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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						
	1	2	3	4	5		
Diphtheria, Tetanus, Pertussis (DTP, DTaP)							
DT (<7 yrs.)/ Td (>7 yrs.)							
Tdap Booster							
Haemophilus influenza Type b (Hib)							
Hepatitis B (HepB)							
Polio (IPV, OPV)							
Measles, Mumps, Rubella (MMR)							
Measles							
Mumps							
Rubella							
Varicella							
Chicken Pox Disease History: Yes <input type="checkbox"/> When: Month _____ Year _____							
Verified by: _____ (Health Care Provider)							
Name & Title							
Pneumococcal Conjugate							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
Meningococcal Vaccine							
Human Papillomavirus (HPV)							
Influenza (Recommended)							
Rotavirus (Recommended)							
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 _____



AUTHORIZATION AND RELEASE OF LIABILITY

(for students with food and/or bee sting allergies that may result in anaphylaxis)

I understand that Washington Hebrew Congregation (“WHC”) cannot promise or assure that an environment be created or maintained that is free of a food and/or bees that my child is allergic to, or that he/she will not suffer an allergic reaction, despite the fact that WHC has taken certain precautions and asked parental cooperation in order to minimize the risk of exposure to such food and/or bees.

I further understand that it is the policy of Washington Hebrew Congregation not to administer medicine of any kind to its students (or campers) and that WHC encourages parents and physicians to follow procedures that result in all medications being administered at home, to the extent possible. Nevertheless, in the event of a situation that a teacher, administrator, school nurse, staff member, or other WHC representative deems to be a medical emergency, I hereby authorize them to administer care and/or emergency medications in accordance with my physician’s instructions that have separately been provided to WHC. I understand that such care may not be administered by a trained professional.

I hereby release WHC and any and all of its clergy, officers, directors, staff members, or other representatives (collectively, “WHC Representatives”) from, and hereby agree to indemnify any and all of the WHC Representatives from and against, any and all lawsuits, claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including but not limited to, reasonable attorney’s fees (collectively, “liabilities”), that any of the WHC Representatives may incur or sustain, and directly or indirectly relates to, or arises from or in connection with:

1. Any allergic reaction or anaphylaxis that was or may have been caused, in whole or in part, by exposure to said allergens while at WHC or in connection with school-related activities or events; and,
2. Any WHC Representative’s effort to give (or decision to refrain from giving) treatment to my child in connection with an allergic reaction or symptoms that appear to indicate an allergic reaction.

Student’s Name (please print)

Allergic to:

Parent/Guardian Name (please print) Parent/Guardian Signature

Date



ALLERGY ADDENDUM SCHOOL YEAR 2011 - 2012

Child's name (please print) _____

Classroom teacher's name _____

To the best of my knowledge:

_____ My child has no allergies

_____ My child has allergies *(Fill out the rest of the form below if you check this box)*

My child is allergic to the following:

- If your child **requires medication** at school, please complete and return the each medication needed.
- If your child has a **food allergy**, please complete the **Food Allergy Action Plan** and the **Authorization & Release of Liability** statement.

Additional comments, medications, and/or instructions:

EMERGENCY CALLS:

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent _____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____ 1.) _____	2.) _____
b. _____ 1.) _____	2.) _____

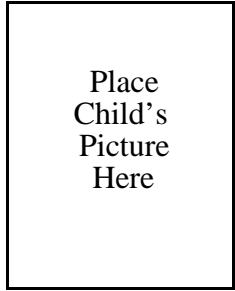
EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Thready pulse, low blood pressure, fainting, pale, blueness
- Other † _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication:**

- | | |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

To be determined by physician authorizing treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____

Date _____

Doctor's Signature _____
(Required)

Date _____

TRAINED STAFF MEMBERS

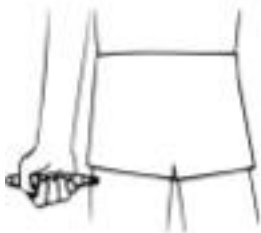
- | | |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

EPIPEN® AND EPIPEN® JR. DIRECTIONS

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.
- Once EpiPen® is used, call the Rescue Squad. State additional epinephrine may be needed. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.



***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*



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: <input type="checkbox"/> M <input type="checkbox"/> F	School or Child Care facility:	
Parent/Guardian Name		Telephone1: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Home Address:			Ward
Emergency Contact:		Telephone2: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		City/State (if other than D.C.)			Zip code:
Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____							
Primary Care Provider (Medical):			Dentist/Dental Provider:		<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other _____		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)
(Please use key to document all findings on line next to each tooth)

Date of Exam _____

- | | | | |
|----------------|----------------|----------------|----------------|
| 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	<input checked="" type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment <input type="checkbox"/> is complete. <input type="checkbox"/> 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;

U: non-restorable/extraction; **UE**: unerupted tooth; **S**: Sealants; **●**: Restoration; **1D**: one surface decay; **2D**: two surface decay; **3D**: three surface decay; **4D**: more than 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.



Physician Medical Form

School Year 2011-2012

TO BE COMPLETED BY CHILD'S PHYSICIAN

Child's full name _____

(Last)

(First)

Address _____
(Street) (City) (State) (Zip)

Home phone _____ Birth date: _____ Weight: _____ Sex: _____

This child has the following condition(s) that may adversely affect his/her education experiences:

_____ Visual _____ Mental, emotional, behavioral
_____ Hearing _____ Other physical illness/impairment
_____ Speech/language _____ **Medication taken regularly**

Please specify: _____

This child has a health condition that may require action while he is at school.

(Please specify, e.g. seizures, bee sting allergies, diabetes, etc.) _____

Recommendations for above _____

Special learning or emotional or social problems this child has experienced are _____

Special schools or assistance received _____

Currently _____ In the past _____

Except as noted above, this child is otherwise in good physical and mental health, is free of communicable disease, has no problems that may interfere with his/her learning and may participate fully in all activities.

Physician's name (please print): _____

Physician's signature: _____

Phone _____ Date _____



Washington Hebrew Congregation
Early Childhood Centers & Primary School

Student Medical Checklist

School Year 2011-2012

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's full name: _____

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know?

	<u>Yes</u>	<u>No</u>	Comments
Allergies (drugs, food, insects)	_____	_____	
Asthma	_____	_____	
Behavioral or emotional problems	_____	_____	
Birth defects	_____	_____	
Bleeding problems	_____	_____	
Chronic diseases	_____	_____	
Chronic infectious diseases	_____	_____	
Diabetes	_____	_____	
Dietary restrictions	_____	_____	
Hearing problems	_____	_____	
Heart problems	_____	_____	
Hospitalizations (when/where)	_____	_____	
Limits on activity	_____	_____	
Medications	_____	_____	
Premature birth	_____	_____	
Problems with bladder	_____	_____	
Problems with bowels	_____	_____	
Seizures	_____	_____	
Speech problems	_____	_____	
Surgeries	_____	_____	
Vision problems	_____	_____	
Other medical conditions	_____	_____	
Is your child toilet trained	_____	_____	

If necessary, please use the reverse side of this form to elaborate on any of the above or for any additional information.

Parent/Guardian name (please print) _____

Parent/Guardian signature _____ Date _____



TRAVEL AND ACTIVITY AUTHORIZATION

✓ **Blanket permission for all given activities**

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

_____ give my permission to WHC
(Name of Child)

Edlavitch-Tyser Early Childhood Center for my child to participate in the following activities:

- ✓ Trips in the van/automobile (parent-owned)
- ✓ Field Trips away from the facility

I understand that the facility will use the appropriate child restraint devices and abide by all the 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.

(Name of Parent/Guardian)

(Name of Child)

Authorization is valid from September 6, 2011 – June 8, 2012

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.

(Name of Parent/Guardian)

(Name of Child)

Authorization is valid from September 6, 2011 – June 8, 2012



Washington Hebrew Congregation
Early Childhood Centers & Primary School

CONSENT AND LIABILITY WAIVER

I, _____ (parent/guardian) am the parent or legal guardian of _____ (minor child). As lawful consideration for my child being permitted to participate in the activities of the Washington Hebrew Congregation Religious School (the "School"), including, without limitation, any transportation provided to my minor child by an employee, officer, director, volunteer, agent or servant of the School (each, an "Authorized Person"), I agree that neither my minor child nor I, nor our respective heirs, assigns, personal representatives or estates, may or will make any claim against, sue or attach the property of the School or of any Authorized Person for damages by reason of death, personal injury, accident, illness or property damage which I or my minor child may sustain as a result of his or her participation in these activities. This release is intended to discharge in advance the School and all Authorized Persons from and against liability, including for negligent acts or omissions, except liability arising out of willful or wonton misconduct by such Person. I further attest that my child is physically fit and has no known medical conditions which would inhibit his or her participation in such at the School and all Authorized Persons.

Should it be necessary for my minor child to have medical treatment while participating in the School activities while under the supervision of an Authorized Person, I give permission to such Authorized Person(s) to use their judgment in obtaining medical services and I give permission to the physician selected by such Authorized Person to render medical treatment as such physician deems necessary or appropriate. I understand the School may not carry insurance covering such medical or hospital costs and agree that any such costs shall be my sole responsibility.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY FOR MYSELF AND MY CHILD AND A CONTRACT BETWEEN MYSELF, MY CHILD AND THE SCHOOL AND ITS EMPLOYEES, OFFICERS, DIRECTORS, VOLUNTEERS AND AGENTS, AND I HAVE SIGNED IT OF MY OWN FREE WILL.

I also agree that the School and its agents and sponsors may use my child's photograph in future promotions.

Signature: _____ Date: _____

If you do not understand this form, please contact: Steven Jacober, WHC Executive Director at 1-202-362-7100.



FIELD TRIP PERMISSION FORM (3'S AND OLDER) SCHOOL YEAR 2011 - 2012

I hereby give permission for _____ (child's name) to participate in school-sponsored field trips with his/her class. I understand that I will be notified prior to a scheduled field trip and will be given information regarding transportation, destination, lunch or other food, arrival and departure times.

By below executing this form, I acknowledge that parents of students may drive my child to and from the Edlavitch-Tyser/Washington Hebrew Congregation Early Childhood Center field trips, and hereby release the E-T ECC/WHC and any and all of its officers, directors, staff members, agents and other representatives from any and all claims, demands, losses, judgments, actions, causes of actions, obligations and other liabilities that may arise by reason of or in connection with the use of any non-E-TECC driver.

DC law requires that **children under 8 years of age must be properly seated in an installed infant, convertible (toddler) or booster child seat**, according to the manufacturer's instructions. Booster seats must be used with both lap and shoulder belts.

By below executing this form, I agree to provide an appropriate seat for my child to participate in school field trips.

Parent/Guardian signature _____

Please print name _____

Home phone _____

Business phone _____

Cell phone _____

Date _____



Carpool Permission Form

SCHOOL YEAR 2011-2012

Every child must have a carpool permission form on file, even if the child's parents/guardians are the only drivers.

Child's name _____

My child _____ has my permission to be picked up from school at any time by the following individuals:

Name:	Relationship to child:	Home/Mobile Phone:
_____	_____	H: _____ M: _____
_____	_____	H: _____ M: _____
_____	_____	H: _____ M: _____
_____	_____	H: _____ M: _____
_____	_____	H: _____ M: _____
_____	_____	H: _____ M: _____

No child will be released to anyone other than those listed above or on the emergency form unless a note (or phone call) is received from the parent or guardian.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____



EDLAVITCH-TYSER EARLY CHILDHOOD CENTER
Enrollment Agreement
2011-2012

Please read the following items carefully. **Two copies are provided so that you may keep one for your records.** This copy must be signed and returned to the school office.

1. Students are registered for an entire school year, or from the time they enter until the end of the school year.
2. No refunds, adjustments, or deductions of any kind will be made from fees, charges or tuition paid due to absence or withdrawal of any student by a parent or guardian during the school year. The school shall not be required to mitigate damages.
3. The school reserves the right to exclude, withdraw or dismiss any student from classes or from the school for any cause whatsoever, including, but not limited to, violation of any rules or regulations, non-payment of fees and tuition, or for any other reason, if exclusion, withdrawal or dismissal is deemed by the school to be in the best interest of the school or student.
4. All children will be accepted for a period of six weeks to determine adaptability to our school. Without limiting the provisions of (3) above, the school expressly reserves the right to require the withdrawal of any child who, after this period, is not adjusting satisfactorily. Withdrawals for adaptability/adjustment reasons will be made by the school administration in writing, and in this event, any unused portion of tuition will be refunded on a pro-rated basis.
5. If, in the judgment of a teacher, director or other responsible WHC employee or a representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.
6. A recent medical checkup and medical form noting current dates of all immunizations is required **prior** to the time the student enters the school.
7. Temple members must participate in our fair share program and be current through June 30 of the school year for which the child has been registered.

I understand and agree that tuition payments are due according to the dates designated in the Fee and Payment Schedule issued by the Edlavitch-Tyser Early Childhood Center, a copy of which is enclosed with this Enrollment Agreement.

I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by the school regulations.

Parent/Guardian Name (print) _____ Date _____

Parent/Guardian Name (print) _____ Date _____



PLEASE RETAIN FOR YOUR FILES

EDLAVITCH-TYSER EARLY CHILDHOOD CENTER 2011 - 2012

Enrollment Agreement

Please read the following items carefully. **Two copies are provided so that you may keep one for your records.** This copy must be signed and returned to the school office.

1. Students are registered for an entire school year, or from the time they enter until the end of the school year.
2. No refunds, adjustments, or deductions of any kind will be made from fees, charges or tuition paid due to absence or withdrawal of any student by a parent or guardian during the school year. The school shall not be required to mitigate damages.
3. The school reserves the right to exclude, withdraw or dismiss any student from classes or from the school for any cause whatsoever, including, but not limited to, violation of any rules or regulations, non-payment of fees and tuition, or for any other reason, if exclusion, withdrawal or dismissal is deemed by the school to be in the best interest of the school or student.
4. All children will be accepted for a period of six weeks to determine adaptability to our school. Without limiting the provisions of (3) above, the school expressly reserves the right to require the withdrawal of any child who, after this period, is not adjusting satisfactorily. Withdrawals for adaptability/adjustment reasons will be made by the school administration in writing, and in this event, any unused portion of tuition will be refunded on a pro-rated basis.
5. If, in the judgment of a teacher, director or other responsible WHC employee or a representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.
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I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by the school regulations.



Washington Hebrew Congregation E-T ECC Fee and Payment Schedule 2011 - 2012

Program	Tuition		Tuition Deposit Paid with Application*	Additional Advance Tuition Payments	Total Tuition Deposits	Balance (billed Aug 1, 2009)		Payments of remaining balance		Must be paid by:
	Member	Non-Member				Member	Non-Member	Member	Non-Member	
2-Day	\$3,435	\$3,990	\$300	\$500	\$800	\$2,635	\$3,190	\$1,581 \$1,054	\$1,914 \$1,276	July 31, 2011 Nov. 30, 2011
3-Day	\$4,390	\$5,105	\$300	\$500	\$800	\$3,590	\$4,305	\$2,154 \$1,436	\$2,583 \$1,722	July 31, 2011 Nov. 30, 2011
5-Day	\$6,135	\$7,130	\$300	\$500	\$800	\$5,335	\$6,330	\$3,201 \$2,134	\$3,798 \$2,532	July 31, 2011 Nov. 30, 2011
Pre-K Full Day	\$10,005	\$11,635	\$300	\$500	\$800	\$9,205	\$10,835	\$5,523 \$3,682	\$6,501 \$4,334	July 31, 2011 Nov. 30, 2011
Toddlers	\$435	\$505				Pay tuition in full with registration form				
Mid-Year 2	\$1,690	\$1,965	\$300	\$0	\$300	\$1,390	\$1,665			Nov. 15, 2011

*In addition to this deposit, a \$55 ECC application fee was paid at time of registration. This amount was not applied towards tuition. Each registered family will also be charged a security fee: **\$175** (WHC members) or **\$245** (non-members).

Tuition is based on a 9 1/2 month school year (September through mid-June). If more than one child in the same family is registered, there is a five percent reduction in the tuition for each additional child(ren). This reduction will be reflected on your initial tuition bill from the Temple accounting office.

All Temple and ECC financial obligations must be current before your child may enter school this coming school year. To keep your account current, please make your payments according to this fee and payment schedule. Until your account is paid in full, you will continue to receive a monthly bill from the Temple. If you have any questions, please contact the school office at 202-895-6334.



IT'S CHALLAH TIME FALL 2011

The Parents' Committee is delighted to offer you the opportunity to purchase fresh baked challah from Bethesda's Best Bakery - Breads Unlimited.

You can purchase challah for every Friday from September 16, 2010 - January 27, 2011 for \$60. This comes out to 17 loaves \$3.50 each -- .about 25 cents off the bakery price.

Challah will be backpacked every Friday except when school is closed. This is a wonderful opportunity to bring a taste of Shabbat into your home.

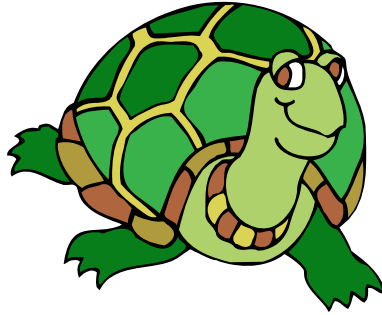
Please return orders to envelope by the office by Monday, September 12.

Return bottom portion

Child's Name: _____

Class Name: _____

Make checks payable to WHC for \$60.00

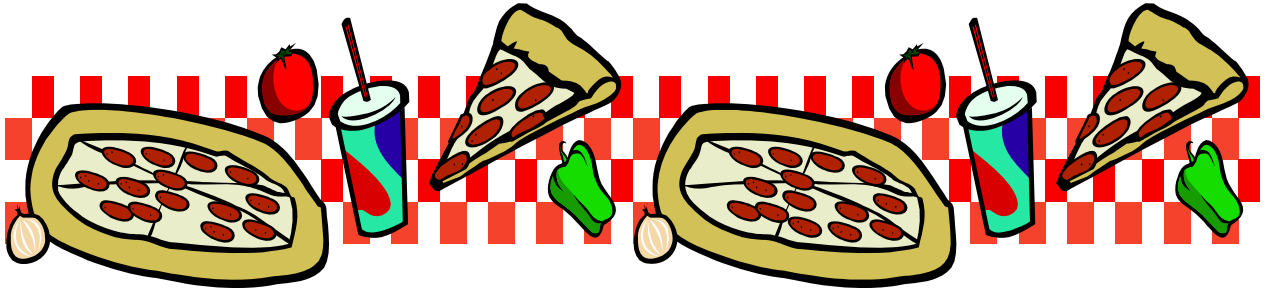


SAVE THE DATE:
Parents' Committee
Welcomes
E-T ECC New Families
Sunday, August 28, 2011
9:30 - 11 am
Turtle Park
45th and Van Ness Streets
Washington, DC
(street parking available)

For more information on the park, go to:

www.turtlepark.org

Back to School Pizza Picnic Party



Join us for our Annual Back to School Picnic

Date: Thursday, September 8

Time: 5 – 7 p.m.

Location: Grassy play area by playground

We provide the pizza and popsicles

You bring drinks and a blanket for your family

We hope to see everyone there.



RSVP to E-T ECC office at llieberman@whctemple.org.

Please tell us your family name and how many
adults and children will attend