Broadcasters' Child Development Center

Admissions Folder Checklist

Section 1 – General Administrative Documents

- ✓ Parent Contract
- ✓ Tuition Rates (2019-2020)
- ✓ Center Contact Information
- ✓ Tadpoles Welcome Letter

Section 2 – BCDC's Internal Forms

- ✓ Emergency Contact Card
- ✓ Infant / Toddler Development Form
- ✓ Parent Participation Form
- ✓ Directory Permission Form
- ✓ Photograph Permission Form
- ✓ Sunscreen Permission Form

Section 3 – OSSE's Required Forms

- ✓ Health Certificate
- ✓ Oral Health (Dental) Certificate
- ✓ Medical Treatment Authorization
- ✓ Medication Authorization
- ✓ Registration Record; Care Away from Home
- ✓ Travel and Activity Authorization
- ✓ Food Allergy Action Plan

Section 4 – BCDC Policies

- ✓ Tuition Policy
- ✓ Sickness / Illness Policy
- ✓ BCDC's Peanut and Tree Nut Policy
- ✓ Medication Policy
- ✓ Inclement Weather Policy
- ✓ Late Policy
- ✓ Room Parent Responsibilities

Please direct questions about this packet to:

Crystal Lewis | Operations Manager
Broadcasters' Child Development Center
3400 International Drive, NW, Box 114
Washington, DC 20008
Phone: (202) 364-8799, Ext. 119
Email: crystal@bcdconline.org

Broadcasters' Child Development Center

PARENT CONTRACT

Last Revision: June 28, 2019

Following are the conditions for enrollment at Broadcasters' Child Development Center:

1. **Changes in Registration Information**: I will notify BCDC's administration immediately of any changes pertaining to the information kept on file for my child.
2. **Deposits**: Upon receiving an offer to enroll at BCDC, I agree to pay a deposit of $550. The deposit is discounted to $275 if my child's sibling(s) is/are currently attending BCDC. My deposit must be paid within five business days of accepting BCDC's offer to enroll. I understand that paying my deposit constitutes full enrollment, and that my deposit will only be refunded if I withdraw from the center with proper notice, return my key fobs and have paid any outstanding balance owed to BCDC.
3. **Re-Enrollment & Withdrawal**: Re-enrollment procedures will begin in February and end in April. In order to maintain continuous enrollment, I must respond to re-enrollment notices on or before their deadlines. If I wish to withdraw my child during June, July, August or September, I understand that two months of written notice is required or I will forfeit my deposit. In the event that I wish to withdraw my child at any other time, I will give the center written notice at least one month prior or forfeit my deposit. BCDC does not prorate tuition for partial months when leaving the Center.
4. **Tuition Procedures**: I will pay my first month of tuition no later than 30 days prior to my first day of school. I agree to pay subsequent tuition installments on or before the first school day of each month. I understand that a $50 late fee will be assessed to my account five calendar days after the due date if I have not paid my tuition installment in full. Because the Center must pay for checks returned due to insufficient funds, I agree to pay all bank fees. If my child will be on vacation for an extended period of time, tuition payment is still required.
5. **Child Illness**: Upon being notified that my child is ill, I agree to arrange to have him/her picked up immediately. I also agree to follow the BCDC sick policy.
6. **Contract Hours and Late Fees**: I agree to contract for care between 8:00 am and 6:00 pm. I understand that if I do not abide by my contract hours, I may be subject to penalties determined by the Director which may include, but are not limited to, a late pick-up fee of $50 per occurrence, suspension or termination, as described in the Late Pick-Up Policy.
7. **Drop-off Policy:** I agree to drop off my child prior to 11:00 am, understanding that late arrival is disruptive to the classroom and can be difficult for the child. Exceptions will be made for doctor's appointments or when given approval by the Center Director in advance. Failure to abide by the drop-off policy may result in my child not being admitted that day, suspension or termination of enrollment.
8. **Dismissal from BCDC**: The Center reserves the right to take any appropriate action, up to and including the right to terminate our child's enrollment if any of the following occur:
    a. The Director and Board Chair determines that our child's behavior threatens the physical or mental health of other children or staff in the Center
    b. Tuition is 15 days or more late
    c. Contract hours are not abided by
    d. Failure to keep our child's health and immunization records current
    e. The program is unable to meet the developmental or social needs of our child
    f. The Director and Board Chair determines that any individual responsible for our child has engaged in inappropriate conduct toward any other member of the Center community.
9. **Outside Consultants**: I grant permission to have my child interviewed, observed or tested by outside consultants as seen fit by the Director with advance notice given.

I agree to abide by the above mentioned conditions of enrollment

Child's Name: _____ Parent/Guardian's Signature: _____

Date: _____ Parent/Guardian's Name (Print): _____

BROADCASTERS' Child Development Center

Monthly Tuition Rates

2018 – 2019

Lambs	$2,395
Ducklings	$2,395
Bunnies	$2,270
Penguins	$2,270
Pandas	$2,140
Fireflies	$1,830
Rainbow Fish	$1,830

**Pricing valid Sept. 1, 2019 to Aug. 31, 2020*

Broadcasters' Child Development Center

Center Contact Information

Kim Mohler | Executive Director
Phone: (202) 364-8799, Ext. 112
Email: kim@bcdconline.org

Ravion Wynn | Assistant Director
Phone: (202) 364-8799, Ext. 110
Email: ravion@bcdconline.org

Crystal Lewis | Operations Manager
Phone: (202) 364-8799, Ext. 119
Email: crystal@bcdconline.org

BCDC's Executive Committee

Margie Yeager	**Andrew Paciorek**	**Chris Krahe**
Co-Chair	*Treasurer*	*Secretary*
Former BCDC Parent	BCDC Parent	BCDC Parent

Please note, BCDC is uniquely housed in a building that has addresses on two separate streets. We have found it helpful to use these two addresses in different ways; one address is used for business purposes, and the second address is used for mail, shipping and when providing driving directions to someone who may be using a GPS. We are providing these two addresses for your convenience:

Our Business Address:
Broadcasters' Child Development Center
3400 International Drive, Box 114
Washington, DC 20008

Our Mailing and GPS-Friendly Address:
Broadcasters' Child Development Center
3007 Tilden Street, NW
Washington, DC 20008

www.bcdconline.org

###

Dear BCDC Families,

Keeping you involved with the school and your child's daily experiences has always been a priority of ours. We use a program called Tadpoles to communicate with parents.

From Tadpoles, teachers can send photos and videos periodically to allow you to see a glimpse into your child's day! Teachers will also be creating a daily report for each child. This daily report will keep you informed of the daily activities, learning experiences, and care events for your child each day. All photos, videos, and daily reports are emailed to you directly and you can also access them via the free Tadpoles Parent app, available on Apple and Android devices, or online at www.tadpoles.com as well! The daily report is sent when your child is checked out at pick up time on the iPad or by 7pm.

Your Tadpoles account will become a valued memory book, as it stores all information sent for your child within your account, allowing you to always go back in time and look at the precious memories and photos of your child. **To create your account online, please use the following steps:**

- Visit www.tadpoles.com and click log in at the top right
- Select Parents on the left
- Choose sign up under "use a tadpoles account"
- Use the email address that is currently on file with our school
    - If it's a Gmail account, you can sign right in to the account
    - If it's not a Gmail account, enter your email, choose submit and check your email for the link to establish your password

The same login information will be used to access your account via the free Tadpoles Parent app as well. If you need further assistance establishing your account, please visit help.tadpoles.com for additional information.

Tadpoles will continue to strengthen our home-to-school connection. Not only does it allow us to send you real time information about your child's day, but it also enhances your ability to communicate with the school as well. From your Tadpoles parent account, via the app or web, you will be able to enter in morning drop off notes for your child's teachers, mark your child absent, and/or add any additional notes to be communicated to the school.

Each classroom is equipped with an iPad which will be specifically used for the Tadpoles program and My Teaching Strategies. If you see a teacher on a tablet, rest assured, they are only using the device to input information into Tadpoles or MyTeachingStrategies. The devices are restricted, giving teachers limited access to only the Tadpoles & MyTeachingStrategies applications.

We consider all information captured within Tadpoles to be a private communication between our school and our families. No personal information is shared with any external parties and as a parent you will only receive information specifically about your child. The confidentiality of all information is maintained through the security features of the Tadpoles software.

We are very excited to begin utilizing Tadpoles and know it will positively impact the engagement of our families and our home-to-school connection. We feel confident that you will love Tadpoles and the level of involvement it allows you to have with your child's daily experiences while at our school. We are happy to answer any questions or concerns you may have about this exciting program!

Thank you for your patience during this transition!

Broadcasters' Child Development Center

2018/2019 EMERGENCY CONTACT CARD

The info on this card is used at the Center and the card is taken on field trips/walks

Please Print (Both sides of this card must be completely filled out.)

CHILD'S Name _____

Birth Date _____/_____/_____ Sex F M Home Phone _____

Home Address _____

PARENT'S Name _____ Home Phone _____

Parent's Employer/Address _____

Business Phone _____ Mobile Phone _____ Email _____

PARENT'S Name _____ Home Phone _____

Parent's Employer/Address _____

Business Phone _____Mobile Phone _____Email _____

Name of PARENT who is closest to BCDC _____

Please list two people to call in an emergency if you can not be reached. These people are also authorized to pick-up your child if you are unable to do so.

Name _____ Relationship to child _____

Home Phone _____ Business Phone _____ Mobile Phone _____

Name _____ Relationship to child _____

Home Phone _____ Business Phone _____ Mobile Phone _____

Please Print (Both sides of this card must be completely filled out.)

☐ My child has no known allergies

☐ My child is allergic to _____

☐ My child has the following special medical problem _____

_____

Doctor's Name _____

Doctor's Address _____

Doctor's Phone _____

Name of Health Insurance Company _____

Policy Holder's Name _____ Policy Number _____

I authorize BCDC to seek medical treatment for my child until I can be reached and agree that my child will be taken to the nearest hospital for treatment and that I am responsible for any fees incurred.

Parent's signature _____ Parent's signature _____

I give my child permission to go on any BCDC field trip as described in the Center handbook.

Parent's signature _____ Parent's signature _____

Revised 4-1-13

Broadcasters' Child Development Center

Infant/Toddler Development Form

Child's name: _____ Date of birth: _____
(first) (middle) (last) (month) (day) (year)

Prenatal and Delivery Information

Pregnancy: Normal? yes _____ no _____ Term _____

Labor and delivery: Normal? yes _____ no _____ Time _____

Complications, if any:

_____

If C-section, why? _____

Infant distress

Causes:_____

Diagnosis:

_____

Any lasting trauma? _____

General Health

Is your child susceptible to:

Stomach problems _____ Colds _____ Allergies _____

explain: _____

_____

Immunization dates (if necessary, change to reflect the schedule your pediatrician follows)

2 mos. _____ 5 mos. _____ 7 mos. _____ 9 mos. _____

Developmental History

weight at birth _____ present weight _____

height at birth _____ present height _____

has your child's growth been consistent? yes ____ no _____

if no, why? _____

Please give age: Held head up _____ Rolled over _____

Sat up (assisted) _____ (Unassisted) _____

Stood up _____ Walked _____

Feeding: Breast fed? _____ How long? _____ Satisfactory? _____

When weaned? _____ Bottle, formula: _____

Solids, when begun? _____

Any allergies? _____

Verbalization (please give age) Cooing-gurgling _____ Mimic sounds _____

First words _____ What? _____

Habits and Routines

Feeding schedule: please complete based on your child's home schedule:

	breakfast	**lunch**	**dinner**
What time?	_____	_____	_____
For how long?	_____	_____	_____
Bottle, food or both?	_____	_____	_____
Where?	_____	_____	_____
Utensils used	_____	_____	_____

Is your child used to mid-morning or mid-afternoon snacks? _____

What type of food? _____

Any other information you think we ought to know about your child's eating habits: _____

_____

Likes? _____

Dislikes? _____

Toilet Habits

Diapers _____ Training pants _____

Age training began _____ success rate _____

Would you like for us to follow your training schedule? yes _____ no _____

Terms used for:

Toilet: _____ urination: _____ Bowel movement _____

Bowel movements

Average number per day _____ Consistency: solid _____, soft _____, very soft _____

Causes of diarrhea? _____

Tends to get constipated? _____ why? _____

Cure: _____

Sleeping Habits Bedtime: any problems going to sleep at night? _____

awakens happy_____ awakens grouchy _____

Naps (give approximate time and length): a.m. _____ p.m. _____

any problems? _____

Special routines: rocked _____ blanket _____ book _____ music _____ doll/toy _____

other, explain _____

Sleeps on back? _____ on stomach? _____ dark room? _____

Discipline

usual method of discipline _____

who is responsible for discipline? _____

reward for good behavior? _____

any special problems? _____

Playing Habits

Alone: what is your child used to playing with? _____

Attention span (how long)? _____

Where does he/she play: crib? _____ playpen? _____ other, explain _____

What types of games does your child like? peek-a-boo _____ hide and seek _____ patty-cake _____

singing _____ others, list _____

Is your child accustomed to sharing? _____

Do you foresee any problems regarding placing your child in day care (e.g., regression, separation problems, change in eating or sleeping routines, etc.)? _____

_____

How can we help make the transition easier? _____

_____ Revised 3/1/09

Broadcasters' Child Development Center

Ravion Wynn | Assistant Director
Broadcasters' Child Development Center
3400 International Drive, NW, Box 114
Washington, District of Columbia 20008
Phone: (202) 364-8799, Ext. 110
Email: ravion@bcdconline.org

Parent Release - Sunscreen and Insect Repellent

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosol sprays and combined sunscreen and insect repellent are prohibited. First application should be applied at home before bringing your child to school. The teachers will reapply sunscreen in the afternoon.

Sunscreen/sunblock must provide UVB and UVA protection with an **SPF of 15 or higher**. Sunscreen **may not** be used on infants under **6 months** of age unless accompanied by a note from the child's medical provider.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less** and may be applied *no more than once a day*. Insect repellant **may not** be used on infants under **2 months** of age.

All sunscreen/sunblock and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date; and
- appropriate for the age of the child.

I give Broadcasters Child Development permission to apply *(name of sunscreen)*

_____

and/or *(name of insect repellent)*

_____

to my child *(a separate form is required for each child)*,

_____

From: _____/_____/_____ To: _____/_____/_____ (not to exceed one year).

_____ _____

(Parent/Guardian Signature) (Date)

Broadcasters' Child Development Center

Parent Participation

BCDC prides itself on the commitment and contributions parents make to our Center.
Please indicate below whether and how you might like to volunteer at BCDC.

(Please Print)

Child's/Children's Name(s):_____

Parent 1

Parent's Name:_____

Daytime Phone:_____

Evening Phone:_____

Email:_____

__ Fundraising

__ Grant Research & Grant Writing

__ Facility Maintenance; General Repairs (Painting, carpentry, toys, books, playground maintenance etc.)

__ Center Accreditation Support

__ Center Events (Fall picnic, holiday party, achievement picnic, etc.)

__ Computer & IT Support

__ Room Parent

__ Other _____

Parent 2

Parent's Name:_____

Daytime Phone:_____

Evening Phone:_____

Email:_____

__ Fundraising

__ Grant Research & Grant Writing

__ Facility Maintenance; General Repairs (Painting, carpentry, toys, books, playground maintenance etc.)

__ Center Accreditation Support

__ Center Events (Fall picnic, holiday party, achievement picnic, etc.)

__ Computer & IT Support

__ Room Parent

__ Other _____

Last Revision:
5/17/18

Broadcasters' Child Development Center

Directory Authorization

This form provides BCDC with permission to publish your family's information in the Center directory. The purpose of the directory is to provide enrolled families with contact information which can be used for arranging playdates, birthday parties, etc. By signing this form, you agree not to sell, share or otherwise disseminate this information in any unauthorized manner.

Please complete one form for each enrolled child, fill in all appropriate areas and sign below.

Please Choose One Option: [ ] **I CONSENT** [ ] **I DO NOT CONSENT**

Child's Name: _____

Parent's Name: _____
Parent's Daytime Phone #: (_____) _____ — _____
Email Address: _____

Parent's Name: _____
Parent's Daytime Phone #: (_____) _____ — _____
Email Address: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____

Home Telephone #: (_____) _____ — _____

I agree to abide by the usage and privacy policies outlined on this authorization form.

Parent's Name (Print): _____

Parent's Signature: _____ Date: _____

Last Revision:
5/17/18

Broadcasters' Child Development Center

Photo Permission Form

I authorize Broadcasters' Child Development Center (BCDC) to photograph and/or record audio and video of my child while he/she is participating in BCDC programs and activities. I further authorize BCDC to print, publish or otherwise disseminate such photograph(s) and/or audio and video of my child via printed materials, classroom or other BCDC on-site displays, any website operated or maintained by BCDC (e.g., www.bcdconline.org), or by other means.

I understand that BCDC will not publish my child's name or any other identifying or private information. I also understand that such dissemination shall be for the purpose of furthering the educational and/or to promote BCDC.

Please Choose One Option: [ ] **I AUTHORIZE** [ ] **I DO NOT AUTHORIZE**

We also welcome you to direct questions about photo usage to:

Kim Mohler | Executive Director
Phone: (202) 364-8799, Ext. 112
Email: kim@bcdconline.org

Child's Name: _____

Parent/Guardian's Name (Print): _____

Parent/Guardian's Signature: _____ Date: _____

Last Revision:
5/17/18

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	

Home Address:	**Apt:**	**City:**	**State:**	**ZIP:**

Ethnicity: *(check all that apply)* ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer

Race: *(check all that apply)* ❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer

Parent First Name:	**Parent Last Name:**	**Parent Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	

Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ No

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

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

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____/____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Development
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney Failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

❑ High → *complete skin test and/or Quantiferon test*

❑ Low

Skin Test Date: **Quantiferon Test Date:**

Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated

Quantiferon Results: ❑ Negative ❑ Positive ❑ Positive, Treated

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date:	**HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Immunizations	Provide in the boxes below the dates of Immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year):				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				

❑ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ❑ No ❑ Yes

This child is cleared for **competitive sports.** Additional clearance(s) needed from: _____ ❑ N/A ❑ No ❑ Yes ❑ Yes, pending additional clearance

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

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

Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	**Signature:**	**Date:**
Health Suite Personnel Name:	**Signature:**	**Date:**

District of Columbia Oral Health (Dental Provider) Assessment Form

Parent/Guardian Instructions:
Part 1: 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. If the child has no dental provider and is uninsured, then please write "None" in each box.
Part 2: 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 representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

Part 1: Child's Personal Information (to be completed by the parent/guardian)

Child's Last Name:	Child's First & Middle Name:	Date of Birth: MM/DD/YYYY	Gender: ❑ M ❑ F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: ❑ Home ❑ Cell ❑ Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: ❑ Home ❑ Cell ❑ Work	Emergency Contact:		Telephone:
Race Ethnicity: ❑ White Non-Hispanic ❑ Black Non-Hispanic ❑ Hispanic ❑ Asia or Pacific Islander ❑ Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: ❑ Medicaid ❑ Private Insurance ❑ None ❑ Other		

Part 2: Required Parent/Guardian Signatures

Parent/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/guardian: SIGNATURE of parent/guardian: Date:

Dental Provider Instructions:
Part 3: Circle Yes or No in findings column. For Yes, please explain in Comments Section.
Part 4 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 3: Child's Findings and Parent Recommendations (please indicate in findings column)

CONFIDENTIAL FORM

	Findings	Comments
Gingival inflammation	Y N	
Plaque and/or calculus	Y N	
Abnormal gingival attachments	Y N	
Malocclusion	Y N	
Treated Dental Caries	Y N	
Untreated dental caries	Y N	❑ Check box if Urgent
Sealants on permanent molars	Y N	
Cleft lip and palate	Y N	
Preventative services completed	Y N	What kinds of preventative services were completed? ❑ Prophy ❑ Fluoride ❑ Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ❑ is completed ❑ is not completed ❑ under treatment ❑ refused treatment ❑ not necessary.
The child has ongoing ❑ urgent ❑ non-urgent treatment needs and is under treatment ❑ by me or ❑ has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: Phone: Date:

District of Columbia Health Certificate:
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. 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 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 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.

Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

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 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 Physical Conditions: _____

_____

Signature: _____ Relationship to Child: _____

Address: _____

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

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

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 _____ to administer the
Name of Facility
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

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

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 (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:** _____

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Office of the
State Superintendent of Education

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

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

Food Allergy Action Plan

Place Child's Picture Here

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

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ 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. _____ 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)

TRAINED STAFF MEMBERS

1. _____ Room _____

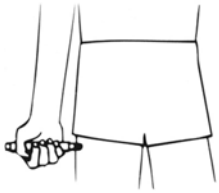
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

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

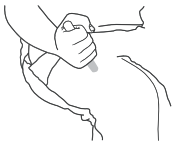


- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

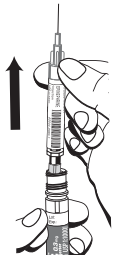
Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**

- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**



<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:



- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**

- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. 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.*

The Food Allergy & Anaphylaxis Network

June/2007

Broadcasters' Child Development Center

Tuition Policy

By action of the Broadcasters' Child Development Center (BCDC) Board of Directors, our tuition policy was amended to read as follows:

- ⇒ Tuition is due on the first school day of each month.
- ⇒ There is a five school-day grace period.
- ⇒ After five days, BCDC will assess a penalty of $5.00 per child, per day to the family's account.
- ⇒ Any family whose payments are late twice within a rolling six month period will be required to participate in the "auto pay" plan. Under this plan, the family's tuition payment(s) will be automatically deducted from a checking account via bank-initiated ACH withdrawal.
- ⇒ This policy was enacted on April 1, 2009.

Please Note: The automatic ACH withdrawal plan is enacted upon the family's completion and submission of an ACH Authorization Form. Please see a member of our staff if you wish to obtain a copy of this form.

Please direct any questions about this policy to:

Crystal Lewis | Operations Manager
Phone: (202) 364-8799, Ext. 119
Email: crystal@bcdconline.org

Revised 5/17/18

Broadcasters' Child Development Center

Illness Policy

Young children are quite vulnerable to illness and infections. In order to keep all of our enrolled children healthy, we ask for your full cooperation in following BCDC's sick policy, the terms of which are outlined below:

1. Please notify the Center if your child contracts or is exposed to any contagious disease.
2. If your child becomes ill at the Center, a parent or authorized individual will be notified and asked to immediately pick up the child.
3. Children sent home with any of the symptoms listed below will need to be kept home for at least 24 hours and must be symptom-free without medication before they can return to the Center:
   - ⇒ Fever above 101 degrees Fahrenheit. Children sent home with a fever must be kept home for at least 24 hours without a fever and the use of medication to reduce the fever before they can return to the Center.
   - ⇒ Colored mucous coming from eyes, nose, ears or mouth
   - ⇒ Pink eye, *i.e.*, colored drainage, eye pain and/or redness of the eye.
   - ⇒ Skin rash - must be diagnosed by a doctor and return to school requires a doctor's note
   - ⇒ Vomiting
   - ⇒ Diarrhea; Loose or watery stools. Child will be sent home after 2 episodes. If Diarrhea continues upon return to school, a doctor's note will be required stating the child is not contagious.
   - ⇒ General feeling of illness, tiredness, or inability to participate in daily routines/activities

If deemed necessary by the Director, you will be required to obtain a doctor's notice stating that any requested tests have been completed and that it is safe for your child to return to the Center. Please direct questions about this policy to:

Ravion Wynn | Assistant Director

Phone: (202) 364-8799, Ext. 110

Email: ravion@bcdconline.org

Revised 5/17/18

Broadcasters' Child Development Center

Peanut & Tree Nut Policy

Given the increasing number of children with life-threatening allergies to peanuts and tree nuts, we are a peanut and tree nut free Center. Below are the guidelines used for governing this policy:

Peanuts and tree nuts, and any foods containing peanuts or tree nuts and their oils, are not allowed at BCDC. On children's birthdays or other special occasions, parents should not order or bring any Asian cuisines to BCDC, as they often rely heavily on peanuts and tree nuts, and are therefore subject to a high degree of cross-contamination when prepared, even if the particular dish does not feature peanuts, tree nuts or their oils.

Tree nuts include almonds, Brazil nuts, cashews, chestnuts, filberts/hazelnuts, hickory nuts, macadamia nuts, Mancelona nuts, pecans, pine nuts, pistachios, and walnuts. Common foods containing peanuts or tree nuts include peanut butter and other nut butters (e.g., almond or cashew butter), as well as some breads, cereal, candies, granola bars and other snacks, muffins and cakes. Corn chips and potato chips are often cooked in peanut oil.

Foods whose labels include allergen warnings such as "may contain traces of peanuts," "processed in a plant that also processes nuts" or "manufactured on shared equipment" will not be purchased by BCDC for use as snacks. Common foods that may contain trace amounts of peanuts or tree nuts include some breads, cereals, candies, granola bars and other snacks, muffins and cakes. Not all food companies label for trace amounts, so BCDC will order food only after clarifying which products are safe for consumers with peanut or tree nut allergies. Parents, while not prohibited from sending foods with such trace warning labels to BCDC, are strongly discouraged from doing so.

Parents of a child with food allergies must notify the staff in writing as to which BCDC-provided snacks their child is permitted to eat. Teachers will notify parents of a child with food allergies when birthdays or other special events are planned to ensure that the parents provide an alternative treat for their child.

The Director, in conjunction with the parents of children with peanut and tree nut allergies, will at the beginning of each school year provide to all parents a letter with information about peanut and tree nut allergies, the BCDC policy prohibiting such foods in the Center, and a list of suggested safe lunch and snack foods for parents to send. This information will also be included in the parents' handbook and made clear to prospective parents.

BCDC staff members and all interested parents will be trained annually and as needed (e.g., for new staff) in how to respond in the event of accidental exposure. Where age-appropriate, BCDC children will also be educated about food allergies and the need to respect any dietary restrictions their classmates may have. Even with a peanut and tree nut-free policy in place, accidental exposure may occur, so training, preparedness and vigilance will remain essential.

Please acknowledge that you have read and understand this policy by signing below.

Parent's Name (Print): _____

Parent's Signature: _____

Date: _____

Last Revision:
May 17, 2018

Broadcasters' Child Development Center

Medication Policy

Non-Prescription Medications: We encourage you to visit the Center to administer over the counter medicines. However, if this is not possible, our trained staff will administer such medications, provided you have a physician's written authorization, the medicine is in the original bottle or package and the medicine authorization form is completed with the following information: your child's name, name of medicine, doses and times the medicine should be administered, name and phone number of the child's physician. Once all information and medicine are provided as described above, a trained staff member will administer the medication and keep a daily record of medication administered. A new prescription is needed with each illness. Sunscreen, insect repellant require a parental permission form, while diaper cream does not.

An allergy action plan should be completed by a parent and physician for any child with a known allergy.

A physician can write standing orders for allergy (and other regularly needed) medicine, but the parent must sign a medicine authorization form for each period of time medication is administered. The medicine authorization form for administering medication will not exceed ten workdays.

If the parent and caregiver determine that as a result of teething your child is uncomfortable and/or presenting a low grade (under 101F) fever, your child's physician may write a 3 month prescription for Acetaminophen (Tylenol or equivalent) that states it is to be given for symptoms relating to teething only.

* Aspirin will not be given at any time because of the danger of Reye's syndrome.

Prescription Medication: In order for our staff to administer prescription medications, the parent/guardian and physician must fill out a medication authorization form with the child's name, name of medicine, doses and times medicine should be administered and then sign the form. Prescribed medication must be given to the caregiver in the original prescription bottle with the pharmacist's label. The name on the bottle is the only person to whom we are authorized to administer the medication and then keep a daily record of the medication administered. As with non-prescription medication, we encourage you to visit the Center to administer the medicine at any time.

Regarding Expiration Dates: Please note, we will not administer any medication or product past its expiration date. This includes, but isn't limited to topical creams, lotions, sun screen and insect repellant.

Ravion Wynn | Assistant Director
Phone: (202) 364-8799, Ext. 110
Email: ravion@bcdconline.org

Last Revision:
May 17, 2018

Broadcasters' Child Development Center

Inclement Weather Policy

In the event of inclement weather, BCDC will follow decisions made by DC Public Schools, including full closure or late opening. In addition, if DCPS closes early because of weather, BCDC will also close early, and parents should pick up their children as soon as possible.

If DCPS was previously scheduled to be closed for students (such as for a holiday, school break, parent-teacher conference day, or any other reason not related to weather), BCDC will follow the decision made for the federal government by the Office of Personnel Management (OPM).

Under unexpected or unusual circumstances, the Center director has full authority to exercise his/her judgment and open or close the center, regardless of decisions made by DCPS or OPM.

Please listen to the radio, TV, or check the DCPS and OPM websites to obtain up-to-date information about DCPS and federal government closures. Center staff will also use the Tadpoles software, text or phone call to communicate with parents and teachers as early as possible, and by 6 am. In addition, parents can call the BCDC Information Line at 202-364-8799, extension 4, and parents will receive an email or text from Tadpoles.

If there is an emergency at BCDC, such as a power outage or non-weather-related event, the director will make a determination as to whether to close the center to protect the health and safety of the children and staff. If the Center is closed early, all parents will be notified through Tadpoles or other means to pick up their children.

Kim Mohler | Executive Director

Phone: (202) 364-8799, Ext. 112

Email: ravion@bcdconline.org

Revised 5/17/18

Broadcasters' Child Development Center

Lateness Policy

We are confident that BCDC families make it a priority to pick up their children on time on a daily basis. However, because we strive to provide the very best care to your children, BCDC must have a policy to discourage late pick-ups. Children often become restless and nervous when they are the last to leave for the day and when parents do not arrive on time. When parents are late, teachers and staff must work longer hours, which becomes costly due to overtime pay requirements. Teachers' schedules and personal lives also are affected when late pick-ups occur. While we understand that unexpected events happen, we hope that you will make every effort to pick up your children on time each and every day.

The following late pick-up policy was implemented on February 1, 2015. This policy will apply on a rolling, 3-month basis, beginning from the date of the first late pick up.

- ⇒ Families are asked to call the center prior to 6:00 p.m. whenever they are going to be late picking up. This notice allows us an opportunity to inform both your child and the teachers of when we should expect your arrival.
- ⇒ First late pick-up: We will give one (1) courtesy allowance.
- ⇒ Second late pick-up: If a parent is late a second time, your account will be billed a $50.00 late fee.
- ⇒ Third late pick-up: If a parent is late a third time, the Director and/or the BCDC Board has the right to request a family meeting.
- ⇒ If late pick-ups continue or are excessive after the third instance, the Director and/or the BCDC Board of Directors may recommend termination of your enrollment at BCDC.

Please direct questions about this policy to Kim Mohler, Executive Director, either by email (kim@bcdconline.org) or by phone at (202) 364-8799, Ext. 112.

Last Revision:
5/17/18

Broadcasters' Child Development Center

Don't Wait to Get Involved!

Become a BCDC Room Parent Today

All parents traditionally devote a significant amount of time to volunteer activities at Broadcasters' Child Development Center. They are largely responsible for BCDC governance and fundraising. Parents are also called upon to help with special projects, such as accompanying children on field trips and performing other minor tasks around the center. This volunteer involvement enhances the quality of programming for our children, and it promotes the free, open communication necessary to establish continuity between home and the Center.

One specific way to get involved is to become a Room Parent. Room Parents coordinate communications between the Director, the Board, and the families enrolled in each of our classrooms. They may help to coordinate the annual teacher appreciation lunch, help with field trips, volunteer for fundraisers, coordinate with parents to choose and purchase a teacher's holiday gift or help with a special event.

If you'd like to become a BCDC Room Parent, please contact our Assistant Director, Ravion Wynn, either by email (ravion@bcdconline.org) or by phone at (202) 364-8799, ext. 110.

Thanks in advance for your involvement!

Sincerely,

The BCDC Administrative Team