Dear Parents/ Gaurdians,

Included in your 2024-2025 daycare packet you will find:

- Ms.P's 2024-2025 Daycare Calender
- Opening Letter
- Welcome Letter
- Sickness Policy
- Field Trip
- Food Program Sheet (eform will be sent via email)
- Medical Forms (dental/physical)
- Drop-Off and Pick-Up Form
- Infant Supply
- Toddler Supply

We will have one awesome year with your little stars. Please let me know if you would like to be added to the parents listserve where we have a group-chat where I sent photo's on a daily bases. Communication is Key just keep us informed of any changes and we will make sure you are aware of our changes and updates.

Angelique Speight

Educational Director

Dear Parents/Guardian,

It's a new school year and your school forms need to be updated. Ms. P's Daycare is committed to staying within the rules, regulations and the state compliance guidelines for the District of Columbia Government and Office of the State Superintendent of Education. If you have already updated your forms this information does not pertain to you.

What does this mean?

In order to stay within guidance the following forms must be completed:

1. Sickness Policy
2. Field Trip/ Permission Form
3. Food Program (eform will be send via email)
4. Medical Forms
5. Drop-Off and Pick-Up Form

Questions to ask yourself?

What if an incident like September 11th happens again? Do you have an emergency plan for my child? The District had Earthquake…What are my plans for my child? What if the cell phone towers go out and I am unable to get in contact with my child or get to them? Who will I authorize to pick my child up in an emergency?

Keep in mind safety is first and here at Ms. P's Daycare STRIVE to put safety first.

During the school year if you move or change any information please inform us immediately. This includes cell/home phone number, residential address, your email address and child pick up authorization.

We follow the District of Columbia Public School System for closing and opening. In the event of an emergency or during inclement weather check your local weather station for updates. As now that COVID is taking over the entire world we must stay safe expect changes until this pandemic is under control.

Sincerely,

Angelique Speight-Marshall

Education

1103 M Street NW, Washington, DC 20005
www.mspsdaycare.com

Dear Parent (s),

Welcome to Ms. P's Daycare. Start by knowing your little learners will shine brightly. It will be a year of magical wonder and amazing education growth for your little star.

The first day of school is an exciting milestone in your child's cognitive and development growth. Your little star is embarking on a journey that will lead them on many roads of discovery and learning. As wonderful as this new experience may be, it can also be quite stressful for your child. New situations and change can, at times, be unsettling for all of us. For many children this may be their first experience of separation from parents or care givers at home. It is common for even the most outgoing child to be anxious the first day of school.

We are looking forward to working with you and your child as we teach them to reach for the stars.

We believe that communication is the key to your child's success and to a great parent/teacher relationship. We encourage you to contact us if you have any questions or concerns at any time. We will also do our part in keeping you up to date with your little stars educational, cognitive and developmental growth with weekly or daily verbal or written communication. If you do feel the need to communicate something immediately know we have an open door policy and we are here to listen. We have parent Meeting 3-times per year, September (previous year), January, and May.

We here at Ms. P's Daycare are eagerly waiting this adventure to begin.

Sincerely,

_____

Angelique Speight- Marshall
Educational Director

Sickness Policy

Dear Parents/Guardians,

The purpose of this letter is to provide information about when to keep your little one home from daycare. Although it may seem obvious, children should not go to school when they're contagious to others, when they have a fever, or when they're too sick to learn. Childhood illnesses are spread easily when children are in close contact in the school setting.

How do you know if your child is contagious?

Colds are a bit tricky, since your child can transmit it to others for one or two days before his symptoms appear, and up to four or five days after first being exposed to the virus. According to the National Institutes of Health (NIH), colds are most contagious two to four days after original exposure (whether or not symptoms have developed), when there is plenty of the virus present in nasal secretions. The contagious period for a cold only lasts about three to four days into the illness. Similarly, people infected with the flu are contagious from a day before they feel sick until their symptoms have resolved. For children, the contagious period for the flu can last up to two weeks after they start feeling sick, even if they start feeling better before that.

Most daycares will send a child home if they think he or she is showing symptoms of the following conditions:

- Fever
- Chicken pox
  Strep throat
- Vomiting and/or diarrhea
- Skin infections
- Eye infections
- Parasitic infections such as lice or scabies

A child with a runny nose or persistent cough, on the other hand, doesn't necessarily pose a health threat to other students, particularly if he's careful to wash his hands frequently. Children recovering from a cold should be able to go to daycare, as long as they're feeling okay. Note that the FDA discourages the use of cold and cough remedies in school-age children, since they are only 6% effective at relieving symptoms.

Please note that if your child presents with any symptom listed above they will not be allowed to attend daycare until they have been seen by their pediatrician and released back. Experts agree that the best method of infection control is simply washing the hands with ordinary soap and water. Additionally, they recommend that schools institute the following infection-control measures: faucets that turn on automatically, bathroom doors that open when you approach them, and wall-mounted dispensers of hand sanitizer.

You can help our little ones stay healthy by teaching them these rules:

- Don't share food.
- Throw away used tissues.
- Wash hands frequently with soap and water.

If you are unsure or have questions about whether your child is well enough to attend daycare, please contact us immediately.

Sincerely,

_____ _____

Angelique Speight -Marshall
Educational Director

Date

Please Sign below indicating you are aware of the sickness policy

---

Student's Full Name _____

Parent/Guardian Signature: _____ Date: _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

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

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

Home Address: _____
Number Street Apt. # State ZIP

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

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

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

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

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

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

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

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

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

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

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

PLEASE TYPE OR PRINT

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

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

Ms P's
Child & Family Services

CHILD DROP-OFF AND PICK-UP AUTHORIZATION

CHILD'S NAME (Please print):_____ DOB: _____

NO ONE WIL BE PERMITTED TO PICK UP YYOUR CHILD IF THEIR NAME IS NOT LISTED BELOW. ALL PERSONS MUST HAVE AND SHOW THEIR PICTURE ID IF ASSIGNED CARPOOL. MAKE SURE YOU LIST ALL ADULTS EVEN IF YOU RESIDE IN THE SAME HOUSEHOLD.

THE FOLLOWING ADULTS ARE AUTHORIZED TO PICK UP MY CHILD FROM Ms. P'S DAYCARE

1. Parent/ guardian (please print) _____

Cell Phone _____ Work Phone_____ Home _____

Address_____ City_____ State_____ Zip_____

2. Parent/ guardian (please print) _____

Cell Phone _____ Work Phone_____ Home _____

Address_____ City_____ State_____ Zip_____

PERSON(S) OTHER THAN PARENT/ GUARDIAN AUTHORIZED TO PICK UP AND/ OR DROP OFF CHILD

1. Name (please print) _____

Cell Phone _____ Work Phone_____ Home _____

Address_____ City_____ State_____ Zip_____

Relationship to child: _____

2. Name (please print) _____

Cell Phone _____ Work Phone_____ Home _____

Address_____ City_____ State_____ Zip_____

Relationship to child: _____

Parent Signature: _____ Date: _____

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

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

DC HEALTH Universal Health Certificate

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

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

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

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

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

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

Parent/Guardian Name:	**Parent/Guardian Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**

Insurance Type: ☐ Medicaid ☐ Private ☐ None **Insurance Name/ID #:**

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

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

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

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

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

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

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

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

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

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

_____

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

What is the child's risk level for TB?

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

☐ Low

Skin Test Date:			**Quantiferon Test Date:**	
Skin Test Results:	☐ Negative	☐ Positive, CXR Negative	☐ Positive, CXR Positive	☐ Positive, Treated
Quantiferon Results:	☐ Negative	☐ Positive	☐ Positive, Treated	

Additional notes on TB test:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____
_____

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

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

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

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

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

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

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

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

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

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

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

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

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

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

Reason:_____

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

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

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

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

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

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

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

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Medication Authorization Form

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1;"A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5,"A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log.

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

I do hereby give permission to _____ to administer the following
Name of Facility

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 staff administering medication who has current medication administration certificate:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE.

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

TRAVEL AND ACTIVITY AUTHORIZATION

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

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

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

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

_____
Explain planned activity - where and when

Field trips away from the facility

_____
Explain planned activity - where and when

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

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

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

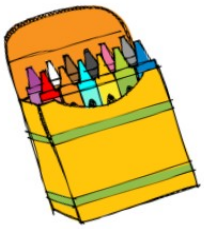
❑ I will not allow my child to play outside the fenced area.

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

_____ _____
Parent/Guardian Signature Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.

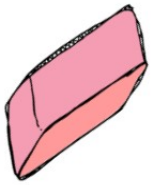
Ms P's
Child & Family Services



Infant Supply List

<u>Please do not label supplies</u>

Diapers Wipes



Diaper Ointment

Baby Formula

Breakfest/Lunch Items Example:

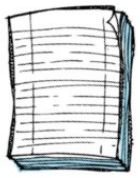
oatmeal, ceral, snaks Extra Bottle/

Sippy Cup Small Blanket

Baby Orajel

2 bottles of hand sanatizer

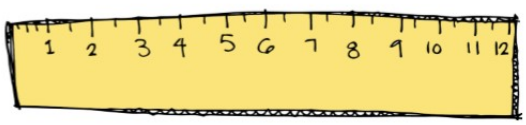
2 boxes of kleenex

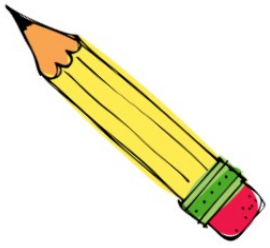


Extra Clothes

Bug Spray

Special Food for Dietary Needs





DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Exhibit A - Photo/Media Release Form

Event: Children and Youth Homelessness Awareness Poster Contest

Location: Washington, D.C.

As the parent/guardian of (child's name) _____, I willingly give permission to have artwork submitted, picture taken and/or voice recorded and grant you permission to use my child's picture, voice and physical surroundings without restriction for the purposes of the Event referenced above, be it print, projection, internet web site, video or any future media market.

I expressly release the Office of the State Superintendent of Education, its employees, agents or representatives or any institution transmitting, or exhibiting my child's picture or voice, from any claims arising from such use or distribution.

I agree to be fully responsible for my child's participation and hold the Office of the State Superintendent of Education, its employees, agents and representatives harmless from any liability, loss of expense arising from the use of my picture or voice. I also consent to the use of my child's name, voice and/or picture, and other material for promotional, publicity, or organizational purposes.

I have read and understand the above:

Child's Name (print): _____

Home Address: _____

Current School & Grade: _____

Parent's Name (print): _____

Signature of parent/guardian (if under age 18): _____

Primary phone #: _____

Email: _____

Date: _____

Office of the State Superintendent of Education

Quality Improvement Network

Improving Early Learning Across Washington, DC

Child Development Home Enrollment Application

(Please print or type clearly)

Application Date	Official Use Only
	Date received:
Age Group (select one)	Received by:
☐ 6 weeks – 12 months	Date enrolled:
☐ 13 -24 months	CP ID:
☐ 24-36 months	Termination date:
Eligible Program (select one)	Provider:
☐ Early Head Start ☐ Private	

Section I - Child to Be Enrolled

First Name	Middle Name	Last Name	Preferred Name
Date of Birth (month/day/year)	Weeks Premature (Put "0" if not Premature)		Gender ___Male___Female

Race	Hispanic	English Proficiency	Other Language & Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other:_____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Poor ☐ Moderate ☐ Proficient

Primary Health Coverage (Select one)

☐ Children's Health Insurance Program (CHIP ☐ Combined Medicaid/ CHIP ☐ Private Health Insurance ☐ State-Only Funded Insurance ☐ Medicaid ☐ No Insurance ☐ Other:_____

Do you have any concerns about your child or children's development? If yes, please explain.

_____

_____

Section II – Parent/Guardian 1 (lives with child)

First Name	Middle Name	Last Name	Preferred Name
Date of Birth (month/day/year)	Gender ___Male___Female	Teen Parent (yes/no)	Provides Financial Support (yes/no)

Race	Hispanic	English Proficiency	Other Language & Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other:_____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply
☐ Master's	☐ HS graduate	☐ Full Time	☐ Full Time & Training.	☐ Natural/Adopted	☐ Yes	☐ Single
☐ Bachelor's	☐ GED	☐ Part Time	☐ Part Time & Training	☐ Step	☐ No	☐ Married
☐ Associate's	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Grandchild		☐ Separated
☐ College Degree/Certificate	☐ Grade 11	☐ Unemployed	☐ Active Military	☐ Niece/Nephew		☐ Divorced
	☐ Grade 10		☐ Retired or Disabled	☐ Foster		☐ Teen Parent
☐ College or Advanced Training	☐ Grade 9			☐ Other (specify)		☐ Military
	☐ < Grade 9					☐ Homeless

Contact Information - Parent/Guardian 1

Living Address (1 or 2 lines for number, street and apartment)	**Mailing Address** (only if different than Living Address)
City, State, Zip **WARD #**	**City, State, Zip** **WARD #**

Home Phone	Work Phone	Mobile Phone	Email Address
- -	- -	- -	

Section III – Parent/Guardian 2 (lives with child? ☐ Yes ☐ No)

First Name	Middle Name	Last Name	Preferred Name

Date of Birth (month/day/year)	Gender	Provides Financial Support (yes/no)
	Male Female	

Race	Hispanic	English Proficiency	Other Language & Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other:_____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply
☐ Master's	☐ HS graduate	☐ Full Time	☐ Full Time & Training.	☐ Natural/Adopted	☐ Yes	☐ Single
☐ Bachelor's	☐ GED	☐ Part Time	☐ Part Time & Training	☐ Step	☐ No	☐ Married
☐ Associate's	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Grandchild		☐ Separated
☐ College Degree/Certificate	☐ Grade 11	☐ Unemployed	☐ Active Military	☐ Niece/Nephew		☐ Divorced
	☐ Grade 10		☐ Retired or Disabled	☐ Foster		☐ Teen Parent
☐ College or Advanced Training	☐ Grade 9			☐ Other (specify)		☐ Military
	☐ < Grade 9					☐ Homeless

Contact Information - Parent/Guardian 2

Living Address (1 or 2 lines for number, street and apartment)	**Mailing Address** (only if different than Living Address)
City, State, Zip **WARD #**	**City, State, Zip** **WARD #**

Home Phone	Work Phone	Mobile Phone	Email Address
- -	- -	- -	

Section IV – Family/Household Information

Child lives with	How many family members are living with child? ____ (such as uncle/aunt, parent, guardian, grandparents, etc.)	How many children under the age of 18 are living in the Household?
☐ No Parent ☐ One Parent/Guardian ☐ Two Parents/Guardian		____Total Children Ages Birth to 18 ____Number of Children Ages Birth to 3 ____Number of Children Ages 3 to 5

List Family Members (do not include parent/guardian and child listed above)

Name	Relationship to Child	Date of Birth (month/day/year)	School/Current Grade or Occupation	Living with Family? (y/n)	Provides Financial Support? (y/n)

Section V – Government Funding Information: Please indicate which of the following services your family already receives.

☐ Medical financial assistance (i.e. Medicaid/Medicare/Chartered)
Insurance Provider and #:_____
☐ Public assistance (i.e. TANF)
☐ Food Stamps (SNAP: Supplemental Nutrition Assistance Program)
☐ Women, Infants, & Children (WIC)
☐ Supplemental Security Income (SSI)
☐ Foster care/Adoption subsidy
☐ Unemployment Insurance
☐ Public Housing Assistance
☐ Energy Program Assistance
☐ Child support/alimony
☐ OSSE Voucher
☐ Other/Specify _____

Section VI- Certification

I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated. I also understand that the information in this application will be held in strict confidence within OSSE and the child development home and is accessible to me during normal business hours.

_____ _____ _____

Print Name (Parent/Guardian) **Signature** **Date**

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Family Participation and Release of Information Agreement

The District of Columbia's Office of the State Superintendent of Education's (OSSE) launched the Early Learning Quality Improvement Network (QIN) in 2015 to improve the quality of care for infants and toddlers in the District. The purpose of the QIN is to expand access to quality early learning for more infants and toddlers by providing continuous care and education that enhances the physical, social, emotional and intellectual development of young children.

Ms.P's Family & Child Services is a part of the QIN. Each child development home in the QIN is supported by a neighborhood-based hub. Easterseals is the hub supporting **Ms.P's Family & Child Services**

Benefits for children and families:

- Infants and toddlers receive care that is nurturing and responsive to their needs.
- Families are linked to comprehensive supports and services at the child care site.
- Children and families will receive continuous, intensive and comprehensive child development and family support services.

By signing this form you are also authorizing **Ms.P's Family & Child Services** to release your child(ren) and family's records to Easterseals and OSSE, as necessary.

Child Development Home:_____

PRINT Parent/Guardian Name: _____

E-mail: _____ Daytime Phone: _____

_____I would like to participate in the Quality Improvement Network initiative, and authorize my provider to release information about my child to the new hub staff.

_____I ***DO NOT*** want to continue participating in the Quality Improvement Network initiative.

Child Name:_____ DOB:_____

Parent/Guardian Name: _____ Date: _____
[Signature]

Provider's Name: _____ Date: _____
[Signature]

QIN Staff Name: _____ Date: _____
[Signature]

Office of the State Superintendent of Education

Quality Improvement Network

Improving Early Learning Across Washington, DC

Child's Name:_____ DOB_____ Sibling: ☐ Yes ☐ No

Determination Date:_____ Enrollment Year:_____

1. Family Name:_____ Number in Family:_____
2. Child meets age requirement for classroom. ☐ Yes ☐ No
3. Income Qualification: **(choose one below)** 1305.6 (b)(ii)

☐ SSI/SSDI– Any Head Start Household Member	100
☐ TANF – Head Start Act 645 (B)(iii) Training/Employed	100
☐ Foster Care	100
☐ Homeless/Shelter – HS Act 645. (B)(i)	100
☐ Income meets 100% or below Guideline HS Act 645.(B)(I)	10
☐ Income meets 101% to 130% Guideline HS Act 645. (B) (iii) (II)	5

***SSI, TANF, and Foster Care children automatically qualify as low-income applicants and are eligible for the program (1305.2 –L). Homelessness automatically qualifies for program (Improving HS for School Readiness Act 2007)**

SELECTION CRITERIA

Available Points	Income Qualification (Points from above)	Check all that apply
50	**HIGH RISK**	
(5)	• Teen Parent	☐
(5)	• Incarcerated Parent	☐
(5)	• Substance Abuse/Addiction/Domestic Violence	☐
(5)	• Child Abuse/Child Service involved 1305.6(b)	☐
(5)	• Parental Loss by Death	☐
(5)	• Chronic Illness/Health Impairment	☐
(5)	• Mental Health Concern	☐
(5)	• Immigrant	☐
(5)	• Military Family	☐
(5)	• Guardianship: ☐ Single Parent ☐ Temporary Custody ☐ Grandparent ☐ Other:_____	☐
25	Disability with IEP and/or IFSP 1305.6 (c)	☐
20	Pregnant mom	☐
10	• Children previously enrolled in another Early Head Start/Head Start Program	☐
10	• Sibling of current children enrolled in Early Head Start/Head Start Program	☐
10	Live in Ward of site to which you are applying	☐
	TOTAL NUMBER OF POINTS	

Completed by:_____ Date Completed:_____ CD Initial:__

ASQ-3 Parent Consent Form

Dear Parents/Guardians,

As part of my curriculum planning, **Ms.P's Family & Child Services** will be using the Ages and Stages Questionnaire-Third Edition (ASQ-3), which is a short screening tool that helps me learn about your child's development. The ASQ-3 distinguishes developmental areas a child may excel in and areas that may need a little extra support. With your permission and participation, I will use the data I collect to plan daily activities to ensure your child's unique needs are met. I will share the results with you and if your child needs additional support, I will send you suggestions of activities you can do with them at home. If there is a need for extra assessment, I will inform you about services offered in DC through the Strong Start Early Intervention Program.

Please read the consent form below and mark the desired option to indicated whether you and your child will participate in the screening/monitoring of your child's development. If you have any questions, please ask me!

Sincerely,

_____ _, director of _____

Parent ASQ-3 CONSENT FORM

☐ I **agree** to allow my child to participate in the Ages and Stages Questionnaires, Third Edition developmental screening. I have read the information provided about the ASQ-3, and I will promptly respond to follow up actions required for further assessment of my child, if needed.

☐ I do **not** wish to participate in the Ages and Stages Questionnaires, Third Edition developmental screening. I have read the provided information about the ASQ-3, and understand the purpose of the program.

_____

Parent/Guardians Signature **Date**

Child's full name: _____

Child's date of birth: _____

of weeks, premature (if the child was born 3 or more weeks prematurely): _____

Ms. P's Child & Family Services

2024 Holiday Calendar

City Holidays

January 1
New Year's Day

January 15
Martin Luther King, Jr. Day

February 19
George Washington Day

May 27
Memorial Day

June 19
Juneteenth

July 4
Independence Day

September 2
Labor Day

October 14
Columbus Day

November 5
Election Day

November 11
Veterans Day

November 27
4 hours additional holiday time

November 28
Thanksgiving

November 29
Day After Thanksgiving

December 24
8 hours additional holiday time

December 25
Christmas

Holiday

Additional Time Off

4 Hrs **8 Hrs**

Please Note: Any additional time off beyond what is published on this calendar, will be determined at the discretion of the Ms. P's and OSSE.

January

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

March

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

List of Holidays and Observances in 2025 (United States)

Date in 2025	Event name	Date in 2025	Event name
1 January	New Year's Day	**8 June**	Pentecost
6 January	Epiphany	**14 June**	Flag Day
20 January	Birthday of Martin Luther King, Jr.	**15 June**	Father's Day
9 February	Super Bowl Sunday	**19 June**	Juneteenth
14 February	Valentine's Day	**4 July**	Independence Day
17 February	Washington's Birthday (Presidents' Day)	**15 August**	Assumption of the Blessed Virgin Mary
5 March	Ash Wednesday	**1 September**	Labor Day
9 March	Daylight Saving Starts	**7 September**	Grandparents Day
17 March	Saint Patrick's Day	**13 October**	Columbus Day
1 April	April Fool's Day	**31 October**	Halloween
13 April	Palm Sunday	**1 November**	All Saints' Day
17 April	Maundy Thursday	**2 November**	Daylight Saving Ends

Date in 2025	Event name	Date in 2025	Event name
18 April	Good Friday	**11 November**	Veterans Day
20 April	Easter	**27 November**	Thanksgiving Day
22 April	Earth Day	**28 November**	Black Friday
5 May	Cinco de Mayo	**8 December**	The Immaculate Conception of The Blessed Virgin Mary
11 May	Mother's Day	**25 December**	Christmas
26 May	Memorial Day	**31 December**	New Year's Eve
29 May	Ascension of Jesus		