



Enrollment Checklist for School Year 2025-2026

Name: _____ Date: _____

_____ **New Student** _____ **Returning Student**

- _____ PowerSchool Registration Online Application
- _____ **MSDC Seat Acceptance Form (New Students Only)**
- _____ **OSSE Home Language Survey (New Students Only)**
- _____ **Final Report Card (Required for New Students entering 1st and 2nd grade)**
- _____ **District of Columbia Universal Health Certificate (Submit by 1st Day of School)**
- _____ **District of Columbia Universal Oral Health Certificate (Submit by 1st Day of School)**
- _____ **Proof of District of Columbia Residency**
- _____ **Parent/Guardian's Photo-ID (New Students Only)**
- _____ **Child's Birth Certificate (New Students Only)**
- _____ **Legal Guardianship or any other Court-Ordered Documentation (if applicable)**

Learn today. Lead tomorrow.

701 Howard Road S.E, Washington, DC 20020

Cedar Tree Academy

Registration

Student Information

Student's Legal First Name

Grade Level for 2025-2026

Student's Legal Last Name

Student's Legal Middle
Name

Suffix

Date of Birth

Gender

Are you or your spouse a member of the military?

Student's Primary Address

Is the student's mailing address different than the physical address listed above?

Please provide below the student's primary address. Please note that this address should be the address of the primary legal guardian / parent / caregiver.

Please confirm that the student is a DC Resident?

Street

Apt/Suite Number

City

State

Zip

Please choose the address type for the address provided above

Does the student's physical address need to be changed?

Please choose which of the following situations the student currently resides in (you can choose more than one):

- ☐ House or apartment with parent or guardian
- ☐ Motel, car, or campsite
- ☐ Shelter or other temporary housing
- ☐ With friends or family members (other than or in addition to parent/guardian)

Ethnicity and Race Report

This form is to be filled out by the student's parents or guardians, and both questions MUST be answered. Part A asks about the student's ethnicity and Part B asks about the student's race.

Part A - Ethnicity

Is the student Hispanic / Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)?

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the next question by selecting from one or more of the dropdowns below to indicate what you consider this student's race to be.

Part B - Race

- ☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America including Central America, and who maintains a tribal affiliation or a community attachment.
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- ☐ **Black or African American:** A person having origins in any of the black racial groups in Africa.
- ☐ **Native Hawaiian or other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Choose one or more:

Race(s)

Family Information

Parent/Guardian 1

Title

First Name

Middle Name

Last Name

Suffix

Gender

Relationship to Student

Emergency Contact

Has custody

Can pick up student

Lives with student

Resides at

Parent/Guardian 1 Contact Information

Phone 1 Number

Phone 1 Type

Preferred phone number?

Phone 2 Number

Phone 2 Type

Preferred phone number?

Phone 3 Number

Phone 3 Type

Preferred phone number?

Employer

Email Address

Parent/Guardian 2

Title

First Name

Middle Name

Last Name

Suffix

Gender

Relationship to Student

Emergency Contact

Has custody

Can pick up student

Lives with student

Resides at

Parent/Guardian 2 Contact Information

Phone 1 Number

Phone 1 Type

Preferred phone number?

Phone 2 Number

Phone 2 Type

Preferred phone number?

Phone 3 Number

Phone 3 Type

Preferred phone number?

Employer
Email Address

Additional Parent/Guardian

*Would you like to add
another parent/guardian?*

Emergency Contact Information

Please list emergency contacts other than , , ,

Emergency Contact 1

Title
First Name
Middle Name
Last Name
Suffix
Relationship to Student
Has custody
Can pick up student
Lives with student

Emergency Contact 1 Contact Information

Phone 1 Number
Phone 1 Type
Preferred phone number?
Phone 2 Number
Phone 2 Type
Preferred phone number?
Phone 3 Number
Phone 3 Type
Preferred phone number?
Email Address

Emergency Contact 2

Title
First Name
Middle Name
Last Name
Suffix
Relationship to Student
Has custody
Can pick up student
Lives with student

Emergency Contact 2 Contact Information

Phone 1 Number
Phone 1 Type
Preferred phone number?
Phone 2 Number
Phone 2 Type
Preferred phone number?
Phone 3 Number
Phone 3 Type
Preferred phone number?

Email Address

Emergency Contact 3

Title

First Name

Middle Name

Last Name

Suffix

Relationship to Student

Has custody

Can pick up student

Lives with student

Emergency Contact 3 Contact Information

Phone 1 Number

Phone 1 Type

Preferred phone number?

Phone 2 Number

Phone 2 Type

Preferred phone number?

Phone 3 Number

Phone 3 Type

Preferred phone number?

Email Address

Emergency Contact Priority

To adjust the priority in which emergency contacts will be called, please select the appropriate order number next to the name.

Home language details

What is the primary language used in the home?

What is the language most often used by the student?

What language or languages did the student use first?

What other languages are spoken in your home?

New to the US and prior schooling details

Is the student new to the US?

Date First Enrolled in a US Public School

☐ Check here if the student has yet to enroll in a US School.

Is the student a Migrant

Students?

Please enter school attended for the last 3 years

Did the student attend a US school in the school year 2024-2025?

Did the student attend a US school in the school year 2023-2024? Did the

student attend a US school in the school year 2022-2023?

Special Education

Abbreviations

IEP - Individualized Education Program

504 Plan

Please Check All That Apply

- ☐ Student has never had an IEP, IFSP, or 504 plan
 - ☐ Student has had an IEP, IFSP, or 504 Plan in previous years
 - ☐ Student has a current IEP
 - ☐ Student has a current IFSP
 - ☐ Student has a current 504 plan
-

Please check all the assessment copies that are available for the student. If you have copies of the assessments that you have checked please provide it directly to the school.

- ☐ None
- ☐ Current IEP
- ☐ Current IFSP
- ☐ Current 504 Plan
- ☐ Most recent psycho-educational assessments
- ☐ Most recent cognitive assessments
- ☐ Most recent speech/language assessments
- ☐ Any other assessments

NOTE: If you do not have copies of the assessments that you have checked, the school's special education team will contact the student's prior school for it.

Allergies and Medical Information

Allergies

Please provide all allergy and health related information requested below. In addition there are official D.C. health forms that will need to be completed and submitted in person to the school. The links to these forms are provided below.

Does the student have any dietary allergies?

Does the student have any other allergies?

Does your child have an EpiPen for the above mentioned (or any other) severe reactions?

Does the student have any prescribed medications such as emergency inhalers, epinephrine, etc. that may need to be administered during school hours?

Does the student have any medical concerns that the school should be aware of?

Health Forms

Please find below official health related forms. The forms have to be printed and filled out by the student's physician unless mentioned otherwise. The forms will also need the signature of the parent or legal guardian as per the instructions on each form. All of the forms have to be completed and submitted to the school in-person.

District of Columbia Universal Health Certificate - Required. This form has to be completed by the student's doctor

District of Columbia Oral Health Assessment Form - Required. This form has to be completed by the student's dentist.

Medication and Medical Procedure Treatment Plan - If applicable, please provide this completed form to the school.

Official Action Plan For Anaphylaxis - If applicable, please provide this completed form to the school.

Official Asthma Action Plan - If applicable, please provide this completed form to the school.

Special Dietary Needs Form - If applicable, please provide this completed form to the school.

Authorizations

Not Doubly Enrolled

I understand that I cannot maintain enrollment at more than one school for 2025-2026.

Records Release

I authorize my student's records to be released by the previous school.

Award of Current Space

I understand that once this form is submitted, I will give up my space at my current school for next school year (2025-26) and my current school will be notified that my space may be awarded to another family.

Removal from Waitlist

I understand that if I enroll as a result of receiving a waitlist offer from this school that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Photo and Video Release

Do you authorize Cedar Tree Academy and/or its agents to take and publish photographs of your child for educational purposes and for purposes of promoting the school?

Do you authorize Cedar Tree Academy and/or its agents to record and publish video(s) of your child for educational purposes and for purposes of promoting the school?

Permission to Go Off School Grounds

Do you authorize your child to leave the school grounds in the company of a Cedar Tree Academy staff member for the purpose of educational, athletic, or recreational activities?

Before and AfterCare services

Cedar Tree Academy provides After Care services on the school premises. Please indicate if you are interested in enrolling the student in After Care services. Please note that there are applicable fees. More information on the After Care services is available on the Cedar Tree Academy website. <http://cedartree-dc.org/for-parents/before-aftercare/>

I am interested in enrolling the student in Before and/or AfterCare services

Documents

Proof of DC Residency (All Students)

Verify by submitting supporting documentation. All items must include the same name and address of the enrolling person as completed on the DC residency verification form and school-based enrollment documents.

ONE item is needed from this list to verify residency.	TWO items are needed from this list to verify residency.
<ul style="list-style-type: none"> • A valid pay stub is sued within 45 days of the school's review of this form. Must contain withholding of only DC personal income tax for the current tax year and no other states listed for deduction, even if the amount is zero. It must also show a DC personal income tax withholding amount greater than zero for both the current tax year and current pay period. • Unexpired official documentation of financial assistance from the Government of the District of Columbia, issued to the enrolling person within the past 12 months and current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs. • Certified copy of Form D40 by the DC Office of Tax and Revenue, with evidence of payment of DC taxes for the current or most recent tax year and must bear the DC Office of Tax and Revenue stamp. • Current military housing orders or statement on military letterhead, must be official correspondence and cite the specific DC address of residence. • Embassy letter issued within the past 12 months. Must contain an official embassy seal and signature of embassy official; and indicate that the enrolling person and student or the adult student currently reside, or will reside, on embassy property in DC during the relevant school year. 	<ul style="list-style-type: none"> • DC motor vehicle operator's permit or official government-issued non-driver identification that is valid and unexpired. • DC motor vehicle registration that is valid and unexpired. • Lease or rental agreement that is valid and unexpired. with a separate proof of payment of rent, such as receipt of payment, money order, or copy of cashed check. <p>The lease must contain the start date, monthly rent amount, name of landlord, and be signed by the enrolling person and landlord.</p> <p>The separate proof of payment must be for a period within two months immediately preceding the school's review of this form and match the monthly rent amount stated on the lease.</p> <ul style="list-style-type: none"> • Utility bill (only gas, electric, and water bills are acceptable) with a separate paid receipt showing payment of the bill, such as receipt of payment printout, money order, or copy of cashed check. <p>The utility bill must be for a period within the two months immediately preceding the school's review of this form.</p> <p>The separate proof of payment must be for the specific bill submitted. The most common submission is two consecutive bills where the second bill shows payment on the first bill. A credited amount on a bill and government agency letter subsidizing payment for utility are also acceptable proofs of payment.</p>

If you are unable to verify through one of the above methods, speak with your school official about a home visit or other options.

Note: Document uploads are optional, please note that forms can be submitted in person, when available. Cedar Tree Academy also reserves the right to request hard copies of all uploaded documents.

Please choose the type of
proof you want to upload

Birth Certificate (New students only)

Please upload Child's Birth
Certificate NO DOCUMENT UPLOADED

Parent Photo ID (New students only)

Please upload Parent's
Photo ID NO DOCUMENT UPLOADED

Final Electronic Signature

Confirmation of Enrollment

I understand that by submitting this form, I am confirming the enrollment of the student above in the enrolling school for 2025-2026.

The electronic signature below and its related fields is treated by Cedar Tree Academy like a physical handwritten signature on a paper form and is legally binding. I affirm that all the information provided by me in this enrollment form is true and correct to the best of my knowledge. Furthermore, I understand that if false information is provided to Cedar Tree Academy it can result in the denial of enrollment of my child for the 2025-2026 school year.

I Agree

Electronic Signature

Relationship to Student

Date



SEAT ACCEPTANCE FORM

2025-26 School Year

Parents/Guardians: If you participated in the My School DC lottery, please complete this form to confirm your child accepts a seat in **Cedar Tree Academy PCS** and submit it with **our** other enrollment requirements.

Student Information

You must fill out one form for each child you are enrolling that participated in the My School DC lottery.

First and Last Name:

Date of Birth (MM/DD/YYYY):

Current School (2024-25):

Current Grade (2024-25):

Enrolling School (2025-26):

Enrolling Grade (2025-26):

Records Release

Please read and sign the bottom of this form so that **Cedar Tree Academy PCS** can request your child's records.

By signing this form, I authorize **Cedar Tree Academy PCS** to request records from the current school for the student above. I also hereby authorize **Cedar Tree Academy PCS** to request records from any other previous schools that the student above has attended. I understand that **Cedar Tree Academy PCS** will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation

Please read and sign the bottom of this form to confirm your understanding of each statement and your child's enrollment for 2025-26.

I understand that I cannot maintain enrollment at more than one school for 2025-26 and I am confirming my enrollment at **Cedar Tree Academy PCS**.

I understand that once this form is submitted, I will give up my space and feeder pattern at my current school (you will still maintain rights to your K-12 DCPS in-boundary schools) for next school year (2025-26) and my current school will be notified that my space may be awarded to another family.

I understand that if I enroll as a result of receiving a waitlist offer from **Cedar Tree Academy PCS** that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Parent/Guardian Information

This should be the same person completing the form.

Signature: _____

Print Name: _____

Date: _____

FOR OFFICE USE ONLY

Application Tracking #: _____



HOME LANGUAGE SURVEY

As part of the enrollment process in DC public and public charter schools, all parents and guardians must complete the Home Language Survey. For all students who are enrolling in a DC school for the first time, parents must complete the OSSE Home Language Survey at the time of enrollment. The purpose of the three questions below is to determine if your child needs English language proficiency screening. If the answers to questions 1, 2 or 3 indicate a language other than English, the school must screen your child for possible identification as an English learner using a screener test.

All DC residents, of all backgrounds, are welcome in public schools in the District of Columbia.

The Home Language Survey is **not** used for immigration purposes and is not shared with Immigration and Customs Enforcement (ICE). The Home Language Survey is **not** used to determine:

- your immigration status;
- your residency status; or
- if your child is an English learner.

Please let your school know if you need assistance completing the Home Language Survey.

This form must be signed and dated by the parent/guardian and school official and kept in the student's file.

Student's Last Name

Student's First Name

School Name

1. What is the primary language used in the home?

2. What is the language most often used by the student?

3. What language or languages did the student use first?

For additional information only:

What other languages are spoken in your home?

Signature of Parent/Guardian

Date

Signature of School Official

Date

To be completed by School Official:

Refer for English language proficiency screening? ☐ Yes ☐ No

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary	
Home Address:		Apt:	City:	State:	ZIP:		
Ethnicity: (check all that apply)		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Other	<input type="checkbox"/> Prefer not to answer		
Race: (check all that apply)		<input type="checkbox"/> American Indian/ Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White	<input type="checkbox"/> Prefer not to answer
Parent/Guardian Name:				Parent/Guardian Phone:			
Emergency Contact Name:				Emergency Contact Phone:			
Insurance Type:		<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private	<input type="checkbox"/> None	Insurance Name/ID #:		
Has the child seen a dentist/dental provider within the last year?				<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____ / _____	<input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight:	<input type="checkbox"/> LB <input type="checkbox"/> KG	Height:	<input type="checkbox"/> IN <input type="checkbox"/> CM	BMI:	BMI Percentile:
Vision Screening: Left eye: 20/____ Right eye: 20/____		<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected	<input type="checkbox"/> Wears glasses		<input type="checkbox"/> Referred	<input type="checkbox"/> Not tested		
Hearing Screening: (check all that apply)		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	<input type="checkbox"/> Uses Device	<input type="checkbox"/> Referred		

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Significant food/medication/environmental allergies that may require emergency medical care.
<i>Details provided below.</i> |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
<i>Details provided below.</i> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Language/Speech | <input type="checkbox"/> Significant health history, condition, communicable illness, or restrictions.
<i>Details provided below.</i> |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> 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? <input type="checkbox"/> High → complete skin test and/or Quantiferon test <input type="checkbox"/> Low	Skin Test Date:		Quantiferon Test Date:	
	Skin Test Results:			
	Quantiferon Results:			

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	1 st Test Date:	1 st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1 st Serum/Finger Stick Lead Level:
	2 nd Test Date:	2 nd Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	2 nd 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:

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.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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).	<input type="checkbox"/>	<input type="checkbox"/>		
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.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant ?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need)	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have pain, abscess, or swelling? (Urgent care need)	<input type="checkbox"/>	<input type="checkbox"/>		
Q6 How many primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns ?	<div>Total Number</div> <table border="1"> <tr> <td></td><td></td> </tr> </table>			
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 ?	<div>Total Number</div> <table border="1"> <tr> <td></td><td></td> </tr> </table>			
Q8 What type of dental insurance does the patient have?	<div>Medicaid</div> <input type="checkbox"/>	<div>Private Insurance</div> <input type="checkbox"/>		
	<div>Other</div> <input type="checkbox"/>	<div>None</div> <input type="checkbox"/>		

Dental Provider Name _____

Dental Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

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.