# Hope Community Public Charter School
## 2025-2026 Student Enrollment Forms

**Below is a list of the forms Hope Community PCS will require a family to provide in order to enroll at the school. These will be collected <u>after</u> the student has been accepted for 25-26 SY.**

**New Student Needed Documents (required once accepted):**

1. **Completion of Enrollment Application Packet (forms include):**
    - DC Residency Verification Form (with proof of DC residency documentation)
    - Student Demographics & Contact Form
    - Authorization for Child's Emergency Medical Treatment Form
    - School Health Services Program Form
    - Medical and treatment authorization Form (if applicable)
    - Oral Health Assessment Form
    - Universal Health Certificate
    - Permissions & Agreements (this includes media release form in relation to photos or videos, off campus activities, extracurricular activities, and transportation for extracurricular activities, practices, games, meetings, & any other upcoming events)
    - Student Meals Form
    - Medical Dietary Accommodation Form
    - Student Food Allergy Disclosure Form
2. **Birth Certificate**
3. **Immunization Documentation**
4. **Home Language Survey (This form is separate from enrollment application packet)**
5. **Last Report Card (if applicable)**
6. **Test Scores (if applicable)**
7. **Request for Records (if applicable)**
    - IEP
    - 504 Plan
    - EL Plan
8. **MySchoolDC Seat Acceptance Form**

**Returning Students (Yearly Required Documentation):**

1. **Student Intent to Return**
2. **Enrollment Application Packet**
    - DC Residency Verification Form (with proof of DC residency documentation)
    - Student Demographics & Contact Form
    - Updated Authorization for Child's Emergency Medical Treatment Form (if needed)
    - School Health Services Program Form
    - Medical and treatment authorization Form (if applicable)
    - Oral Health Assessment Form
    - Universal Health Certificate
    - Permissions & Agreements (this includes media release form in relation to photos or videos, off campus activities, extracurricular activities, and transportation for extracurricular activities, practices, games, meetings, & any other upcoming events)
    - Student Meal Form
    - Updated Medical Dietary Accommodation Form (if needed)
    - Updated Students Food Allergy Disclosure Form (if needed)

# Hope Community Public Charter School

## 2025-2026 Student Enrollment Forms

**Returning Students (Required SIS form updates, if applicable):**

1. **Enrollment Application:**
    - Student Contacts
    - Student Demographics
    - Student Address
    - Medication Orders including medication and treatment authorization

# DC Residency Verification Form – 2024-25 School Year

**Use this form to** verify that you are a District resident and therefore you or your student is eligible to enroll in a DC public or public charter school. All forms and supporting residency documentation are submitted to the enrolling school.

## Step One: Choose the residency verification method that best applies to you.

Details of the available methods for verifying your DC residency are provided on page two. **Choose ONE** after completing sections 2 and 3 below. To be eligible to enroll in a DC public or public charter school tuition-free: 1) the enrolling person must be the parent, adult student, or the valid legal guardian, custodian or Other Primary Caregiver (OPC) with proper documentation; 2) **the enrolling person has established a physical presence in the District of Columbia**; and 3) the enrolling person has submitted valid and proper documentation that establishes residency as set forth in law and regulations.

## Step Two: Provide information about student and enrolling person.

| **Student First Name:** | **Student Last Name:** | **DOB:** |
|---|---|---|
| **Name of School in the 2024-25 School Year:** | | |

| **Enrolling person** (see page 2) **> First Name:** | **Last Name:** |
|---|---|

**I am the:**
- ☐ student's legal parent/guardian/custodian
- ☐ adult student
- ☐ student's Other Primary Caregiver and completed the OPC Form
- ☐ minor parent and completed the sworn statement

| **Address of enrolling person:** | | | **Apt #:** |
|---|---|---|---|
| **City:** | **State:** | **ZIP:** | **DC Resident:** ☐ **Yes** ☐ **No** |
| **Email:** | | **Phone:** | |

## Step Three: Sign Certification of Residency Requirements.

- I certify that I am the adult student or the student's legal parent, guardian, custodian, or Other Primary Caregiver (OPC) and am submitting valid and proper residency documentation accordingly or have identified myself as a non-resident and understand the required tuition agreement and tuition payment needed for enrollment.
- I certify that I have established and will maintain a physical presence in the District, defined as the "actual occupation and inhabitance of a place of abode with the intent to dwell for a continuous period of time"; and I am submitting valid and proper documentation to verify residency, as set forth in 5A DCMR § 5004; or, I have identified myself as a non-resident and will complete the required tuition agreement and tuition payment.
- I consent to the disclosure of whether I was determined to meet the residency requirements for any government funded financial assistance program (such as, Medicaid, Temporary Assistance for Needy Families [TANF], or Supplemental Nutrition Assistance Program [SNAP]) in which I am enrolled for the sole purpose of verifying District residency for DC public or charter school enrollment. By signing below, I am saying: I authorize the Office of the State Superintendent of Education (OSSE) to obtain my personally identifiable DC residency status information from other state or federal agencies, including but not limited to, the DC Department of Human Services (DHS), the DC Housing Authority (DCHA) and the Department of Health Care Finance (DHCF). OSSE will protect my information and follow all applicable laws regarding the protection and use of this information.
- I understand that enrollment of the above-named student in District of Columbia Public Schools, public charter schools, or other schools providing educational services funded by the District of Columbia is based on my representation of **bona-fide DC residency, including this sworn statement of physical presence and my submission of valid and proper documentation verifying residency** or by completion of a tuition agreement and tuition payments.
- I understand that even if the documentation I provide appears to be satisfactory, OSSE or school officials, with reasonable basis, may seek further information to verify the student's residency or the OPC status of the adult enrolling the student.
- If the District of Columbia, through OSSE, determines that I am not a resident or an approved non-resident under 5A DCMR § 5007, I understand that I am liable for payment of retroactive tuition for the student, and that the student may be withdrawn from school.
- I understand that if I provide false information or documentation, I can be referred to DC Office of the Inspector General for criminal prosecution or to the DC Office of the Attorney General for prosecution under the False Claims Act and under DC Code § 38-312 which provides that any person who knowingly supplies false information to a public official in connection with student residency verification shall be subject to payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both a fine and imprisonment.
- I understand that this form and all supporting documentation to this form, including all other OSSE forms used to verify residency, will be retained by the school. I consent to their disclosure to OSSE, external auditors and other District agencies including but not limited to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request, for the purposes of ensuring the accuracy of my District residency.
- I understand that the District of Columbia may use whatever legal means it has at its disposal to verify my residence.
- To verify residency to attend District of Columbia schools, I authorize the Office of Tax and Revenue (OTR) to review and confirm my District tax filings for a period of 3 tax years and to provide the results of that review to the OSSE's Office of Enrollment and Residency.
- **I agree to notify the school of any change of residence for myself or the student within three school days of such change and complete a DC Residency Verification Form**.

**Enrolling Person SIGN HERE: _____ DATE: _____**

## Step Four: Submit this completed form and applicable documentation to your school.

**SCHOOL OFFICIAL USE ONLY** The following method was used to verify District of Columbia residency. Choose ONE method.

I certify, under the penalties of perjury, that I have personally reviewed all the documents presented and affirm that the information represented above is true to the best of my knowledge, information and belief. I also affirm that all supporting documentation to this form will be retained by the school and made available to OSSE, external auditors, and other agencies, including but not limited, to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request.

**School Official Name (print)**: _____ **Signature**: _____ **Date**: _____

**Method A: School official verified**
- ☐ OSSE Residency Verified (QLIK, ASPEN, or CBO Subsidy)
- ☐ Homeless liaison verified
- ☐ Ward of DC

**Method B: Select one document**
- ☐ Pay stub
- ☐ DC Gov. financial assistance
- ☐ Certified DC Tax Form-D40
- ☐ Military housing orders
- ☐ Embassy letter

**Method B: Select two documents**
- ☐ DC motor vehicle registration
- ☐ DC driver's license/non-driver ID
- ☐ Lease with payment
- ☐ Utility bill with payment

- ☐ **Method C:** Home visit
- ☐ **Non-resident**

## Enrolling person, follow ONE of the methods (A-C) to verify your DC residency.

**A**

**Verify with a school official.** If you are experiencing homelessness, a ward of the District and/or a participant of a District public benefits program, such as Medicaid, SNAP, or TANF–your school may already have your information. Check with your school official or the school's homeless liaison.

**Verify through the Office of Tax and Revenue (OTR).** Re-enrolling families/students are often able to verify residency using OTR residency verification process. The enrolling person must have paid taxes in DC during the previous fiscal year and have the student's Social Security number. The student must be re-enrolling in the same local education agency and enrolling in grades K-12. Login to the system at ossedctax.com. If successful, your verification will then be available for your school to confirm.

**B**

**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.**

- A valid **pay stub** issued 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, Supplemental Security Income, housing assistance or other programs.
- **Certified copy of Form D40** by the DC Office of Tax and Revenue (OTR), with evidence of payment of DC taxes for the current or most recent tax year and must bear the OTR stamp.
- **Military housing orders or statement on military letterhead**, issued within the past 12 months and current at the time presented to the school. The housing order must be an official correspondence and cite the specific DC address of residence. The order must indicate that the enrolling person is currently residing and not an intent to reside.
- **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 currently resides, or will reside, on embassy property in DC during the relevant school year.

**OR**

**TWO different items are needed from this list.**

- **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. Temporary registrations are not acceptable.
- **Lease or rental agreement (including a military lease)** 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.
  *The lease* must contain the start date, monthly rent amount, name of landlord, and be signed by the enrolling person and landlord.
  *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.
- **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.
  *The utility bill* must be for a period within the two months immediately preceding the school's review of this form.
  *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. All payments must be confirmed and not scheduled for a future date.

**C**

**Verify through a home visit.** If you are unable to verify through one of the above methods, speak with your school official about a home visit. The visit must occur inside the residence and demonstrate that the enrolling person and the student reside in the home.

## Enrolling as a non-resident student

Non-resident students are only eligible to attend a District public school if there are no eligible DC residents on the waitlist, the LEA agrees to enroll the student, there is a signed tuition agreement in place with the Office of the State Superintendent of Education, and an initial tuition payment has been made. To complete a tuition agreement and tuition payment, please email osse.residency@dc.gov. Non-residents are not eligible for enrollment through the District's Pre-K Enhancement and Expansion Funding Program.

## Persons eligible to enroll a student.

- **Parent** - a natural parent, stepparent, domestic partner, or parent by adoption who has custody or control of a student, including joint custody.
- **Guardian** - an appointed legal guardian of a student by a court of competent jurisdiction.
- **Custodian** - a person to whom physical custody has been granted by a court of competent jurisdiction.
- **Other Primary Caregiver** - is a person other than a parent or court-appointed custodian or guardian who is the primary provider of care or control and support to a student who resides with him or her, *and* whose parent, custodian, or guardian is unable to supply such care and support due to serious family hardship.
- **Adult Student** - A student who is 18 years of age or older, or who has been emancipated from parental control by marriage, operation of statute, or the order of a court of competent jurisdiction.

**Student Demographics & Contact Form**

**School Year:_____**

## Part I: Student Demographics

Student's First Name: _____

Middle Name:_____

Last Name:_____

D.O.B._____

Country of Birth: _____ Town/County of Birth:_____

*USFI# (Staff Enters)*_____

Gender: ☐**M** ☐**F**

Ethnicity:

- ☐ Black/African American
- ☐ White
- ☐ Asian
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other:_____

Is the student hispanic or latino? **Yes** **No**

## Part II: Student Address

*Student Physical Address:*

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

*Student Mailing Address (if different from above):*

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

**Student Demographics & Contact Form**

## Part III: Student Contacts

*Enrolling Parent/Guardian*

Full Name:_____

Relationship to Student:_____

Home Phone Number:_____ Cell Phone Number:_____

Email Address:_____

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

## School-Aged Siblings

| | | |
|---|---|---|
| **Name:** | **Grade:** | **D.O.B.** |
| **Name:** | **Grade:** | **D.O.B.** |
| **Name:** | **Grade:** | **D.O.B.** |
| **Name:** | **Grade:** | **D.O.B.** |
| **Name:** | **Grade:** | **D.O.B.** |

## Emergency Contacts

***Emergency Contact #1*** ☐ *Authorized to Pick Up*

Name:_____ Contact Number:_____

***Emergency Contact #2*** ☐ *Authorized to Pick Up*

Name:_____ Contact Number:_____

***Emergency Contact #3*** ☐ *Authorized to Pick Up*

Name:_____ Contact Number:_____

***Emergency Contact #4*** ☐ *Authorized to Pick Up*

Name:_____ Contact Number:_____

***Emergency Contact #5*** ☐ *Authorized to Pick Up*

Name:_____ Contact Number:_____

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT**

**Date:_____**

If my child _____, date of birth _____,
month/day/year
becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital:_____

Address:_____

OR

Health Provider:_____ Telephone No: _____
M.D./N.P

Address:_____

I give permission to ***Hope Community PCS***, located at ***2917 8th St NE, Washington, DC 20017***, to take my child for treatment. I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company:_____
Name of Policy Holder:_____ Relationship to Child:_____

Policy Number:_____ Coverage:_____

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

Child's Known Allergies or Health Conditions: Yes ☐ No ☐

*If yes, explain:*_____

_____

Home Address:_____
Street City/State Zip Code

Area Code/Telephone No:_____
Home Cell

Signature: _____

Relationship to Child: _____

*Reviewed 12/2024*

# SCHOOL HEALTH SERVICES PROGRAM

Please fill out the form below after carefully reviewing the policies and procedures governing student health services, and then sign the required consents contained in this document. This is required in order for you (if you are a student who is 18 years of age or older) or your child to participate in the School Health Services Program. Please submit the completed document to your child's school registrar.

| Student's Personal Information \| Completed by parent/guardian/student eighteen (18) years of age or older | | | | |
|---|---|---|---|---|
| **Student Last Name:** | | **Student First Name:** | | **Date of Birth:** |
| **School or Child Care Facility Name:** | | | | |
| **Home Address:** | **Apt:** | **City:** | **State:** | **ZIP:** |
| **Ethnic Designation:** *(check all that apply)*<br>☐ Hispanic/Latino ☐ Other ☐ Non-Hispanic/Latino ☐ Prefer not to answer | | | | |
| **Race:** *(check all that apply)*<br>☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander<br>☐ White ☐ Prefer not to answer | | | | |

| Parent/Guardian Information | | | |
|---|---|---|---|
| **Parent/Guardian Name 1:** | | **Parent/Guardian Name 2:** | |
| **Phone:** | **Email:** | **Phone:** | **Email:** |
| **Relationship to Student:** | | **Relationship to Student:** | |
| **Parent/Guardian Phone:** | | **Parent/Guardian Phone:** | |
| **Emergency Contact Name, Relationship to Student:** | | **Emergency Contact Phone:** | |

| Insurance Information | |
|---|---|
| **Insurance Type:**<br>☐ Medicaid<br>☐ Private<br>☐ None | **Insurance Name/ID #:**<br>**Insurance Plan:** |
| **If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance?**<br>☐ Yes ☐ No | |
| **Primary Care Provider Name:** | |
| **Primary Care Provider Organization & Address:** | |
| **Primary Care Provider Phone:** | |



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## SCHOOL HEALTH SERVICES PROGRAM POLICIES AND PROCEDURES

- Students may receive care from a school nurse, school health suite personnel, or trained school staff in accordance with District of Columbia (District) laws and regulations and the District's Department of Health (DC Health) School Health Services Program (SHSP) policies and procedures.
- I understand in order to participate in the SHSP, I must provide consent to allow the student's medical care provider to electronically send my child's health information including, but not limited to the information in the Universal Health Certificate, to my child's school. Information regarding care provided to my child in my child's school may be shared with other District agencies for the purpose of coordinating my child's care and for District-wide data collection, for example to monitor asthma or other health trends in the District.
- My child's health information will always be stored and transferred in accordance with District and federal laws and regulations including, but not limited to the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) act and D.C. Law 18-273, the Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Official Code § 7-241 et seq.)
- A student that is eighteen (18) years of age or older, or an emancipated minor, as defined by D.C. Official Code sec. 7-1231.02 (10) may complete this form for themselves and legally consent to any school health services.
- In accordance with the Minor's Health Consent Regulation (22-B DCMR 600.7) for a minor may legally consent for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered.



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# SCHOOL HEALTH SERVICES PROGRAM ACKNOWLEDGEMENTS AND CONSENTS

- I hereby give consent for my child's school or school health suite personnel to provide a hearing and vision screening test if my child has not received one in the past calendar year according to their submitted Universal Health Certificate.
- I hereby give consent for the school or school health suite personnel to administer prescribed medication and/or treatment to my child as directed by my child's licensed healthcare provider, in accordance with D.C Official Code § 38-651 and in emergency circumstances, in accordance with D.C Official Code § 38-656.

I understand:

- I am responsible for submitting school health forms including but not limited to: Medication and Medical Procedure Treatment Plan, Asthma Action Plan, Anaphylaxis Action Plan, Dietary Accommodation Form or other accepted school health form signed by my child's medical provider to my child's school if my child needs special medical care or medication. I am responsible for submitting an updated school health form annually for my child.
- I am responsible for bringing any needed medication or medical supplies listed on a complete school health form, in their original packaging, to the school nurse. All medication or medical supplies will be stored in a secured area of the school.
- I am responsible for collecting all expired medication kept at school within one week of its expiration date and within one week of the end of the school year. I understand that uncollected medication will be destroyed. Health suite personnel do not assume any responsibility for possible loss of medication or medical supplies.
- I am responsible for immediately notifying the school if any changes occur in the education and Medical Procedure Treatment Plan and providing all updated school health forms to the school. The health suite personnel can be reached by calling the health suite directly or by calling the school's main phone number.
- I understand that the school or school health staff will not assume any responsibility for my child's unauthorized self-medication or treatments. My child may only self-treat or self-administer medication for asthma, anaphylaxis or diabetes if they are approved to self-medicate as directed by a licensed medical provider and in line with a complete school health form.
- I hereby acknowledge and agree that, as provided for in D.C. Official Code sec. 38-651.11, the District, the school, its employees and agents (including school nursing staff) or the practicing physician, physician assistant or advanced practice nurse, who has issued a standing order shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code sec. 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form must be completed and submitted before the student can receive health services.

**Student Name (printed)_____ Parent/Guardian Name (printed)_____**

**Parent/Guardian Signature/Student if age is 18 or older _____ Date _____**



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# SCHOOL HEALTH SERVICES TELEHEALTH PROGRAM TERMS AND CONDITIONS

The School Health Services Telehealth Program allows students to be seen remotely at their school by a medical care provider. By signing below, I understand, acknowledge and agree that:

- My child may participate in appointments conducted by video (videoconferencing) or phone call (teleconferencing) with healthcare providers such as behavioral health providers who may be at an off-school location. The healthcare provider may determine that an in- person follow-up visit or that urgent care or emergency services is required.
- In addition to my child's healthcare team and provider, individuals who operate the video equipment and who are trained to maintain the confidentiality of all information obtained may also be present. The student has the right to request that: (1) specific details of their medical history/physical examination be omitted; (2) non-medical personnel leave the examination room; or (3) the visit be terminated at any time.
- I have the option to refuse a telehealth appointment for my child.
- I authorize the provider or its healthcare personnel to release any and all information to my child's health insurance plan or any other agent that may be responsible for paying medical bills associated with the visit. I further authorize the School Health Services Telehealth Program to release specific medical information to school officials and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.
- My insurance may be billed for Telehealth services. I understand I am responsible for providing insurance information and am responsible for any additional copay or charge resulting from this service. Enrollees in any DC Medicaid Managed Care Organization will not receive a bill for any of the services provided through telehealth. All charges associated with this program are at the discretion of the insurance company. Any copay that is required for primary care visits could apply for this service. I understand that any monies or benefits for providing telehealth will be assigned and transferred to the provider, including benefits/monies from my health plan, Medicaid, or other third parties who are financially responsible for my child's medical care. I authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes.
- If I am not satisfied with the services rendered at any time, I may file a complaint with the Ombudsman team via phone: (202) 724-7491 or via email: healthcareombudsman@dc.gov. Complaints should also be submitted via the School Health Services Program portal at: https://dchealth.force.com/studenthealthservices/s/.
- This consent will be valid for the duration of the student's enrollment in the school. I also understand that I have the right to withdraw my consent at any time by giving the health suite staff a signed and dated letter withdrawing my consent.

**Student Name (printed)_____ Parent/Guardian Name (printed)_____**

**Parent/Guardian Signature/Student if age is 18 or older _____ Date _____**



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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/childcare facility.

## Instructions

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

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

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Student ID _____ Date of Birth (MMDDYYYY): ☐☐/☐☐/☐☐☐☐

Current Gender Identity: _____

Home Address: _____ Home State: ____ Home Zip Code ☐☐☐☐☐

| School Grade | Day-care | Pre-K3 | Pre-K4 | K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Adult Ed. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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

| | Yes | No |
|---|---|---|
| 1. 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). | ☐ | ☐ |
| 2. 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. | ☐ | ☐ |
| 3. Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**? | ☐ | ☐ |
| 4. Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)** | ☐ | ☐ |
| 5. Does the patient have **pain, abscess, or swelling? (Urgent care need)** | ☐ | ☐ |

6. How many **primary teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns?** ☐☐
7. How many **permanent teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns** ☐☐
   - **c. Extracted due to caries?** ☐☐
8. What type of dental insurance does the patient have? Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

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 childcare 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):<br>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: |

## Part IV: Permissions/Agreements

| INDEPENDENT RELEASE AGREEMENT | |
|---|---|
| **Independent Release Agreement:** *I am aware that students in grades 3-8 are permitted to walk or use public transportation at dismissal time with a parent's permission. Students cannot leave independently without the signature of the parent/guardian/caregiver, emergency contact, or authorized pick up.* | ☐ I consent<br>☐ I do not consent |
| **MEDIA CONSENT** | |
| **Off-Campus Activities:** *I give permission for my student to leave the school grounds in the company of Hope Community staff members for the purpose of educational, athletic, or recreational activities.* | ☐ I consent<br>☐ I do not consent |
| **Events:** *I hereby agree and give my permission for the Hope Community Public Charter School (HCCS) and/or partners to record, film, photograph, audiotape or videotape my/my child's name, image, student work, and performance (hereinafter collectively referred to as "Works") and to display, publish or distribute these Works for the purpose of publishing, posting on the HCCS website, posting in schools, posting on social media sites and/or for broadcasting on television or radio as determined by the HCCS. I hereby waive any right to approve the use of these Works now or in the future, whether the use is known to me or unknown, and I waive any right to any royalties related to the use of these Works. I understand that the Works may appear in electronic form on the internet or in other publications outside of the HCCS's control. I agree that I will not hold the HCCS responsible for any harm that may arise from such unauthorized reproduction.* | ☐ I consent<br>☐ I do not consent |
| **Media Specific:** *I also understand that external media organizations may attend school events. I give permission for my/my child's name, image, student work, and performance to be photographed, filmed, audio-taped or videotaped for the purpose of being published and/or broadcast on-line, on television or radio.* | ☐ I consent<br>☐ I do not consent |
| **Photographs for Educational Purposes:** *I give permission for Hope Community and/or its agents to take and publish photographs of my student for educational purposes, and for the purposes of promoting the school and/or its partners (e.g. EL Education).* | ☐ I consent<br>☐ I do not consent |
| **Video for Educational Purposes:** *I give permission for Hope Community and/or its agents to video or publish my student for educational or promotional purposes.* | ☐ I consent<br>☐ I do not consent |
| **EXTRACURRICULAR ACTIVITIES & SPORTS** | |
| Participation in Extracurricular Activities: *I give permission for my child to participate in extracurricular sporting activities at Hope Community Public Charter School during the 2023/2024 school year. It is recognized that participation in athletics or after school activities can lead to injury. My permission evidences that I accept the general liability for the participation of my child in extracurricular sporting activities and that I agree to indemnify and hold harmless Hope Community Public Charter School, its teachers, its coaches, its governing board, and other participating agents either jointly or severally, from and against any and all claims, injuries, damages, loses, costs, or causes of action that may arise in* | ☐ I consent<br>☐ I do not consent |

| | |
|---|---|
| *connection with activities or sports. If my child is participating in sports or athletic activity, my signature indicates that I understand that each participating student must have a physical form from a licensed physician on file in the school office before the first practice of the first sports played each school year. This physical is valid for a calendar year from the date of examination. My signature also shows that I agree, in the event of a medical emergency, to allow my child to be treated by medical personnel as outlined in my Emergency Release Form as well as certified staff, coaches and school agents.* | |

## TRANSPORTATION POLICY FOR ATHLETICS AND ACTIVITIES

Hope Community P.C.S.Athletics and Activities Department is committed to providing safe and reliable transportation for registered students in extracurricular activities, including attending meetings, practices, games, and events.

The ability to ride the school van or contracted transportation to and from school for extracurricular activities and field trips is a privilege, not a right, and may be rescinded at any time. Any instance of breaking the following rules, as reported by the van driver, will result in immediate suspension from the school provided transportation. A second offense will mean that the student may no longer ride the school provided transportation. A warning will not be given for misbehavior, nor will an appeal process be available if the van staff recommends suspension.

1. The driver is responsible for the safe operation of the school transportation and therefore is in charge of the school transportation while it is in use. Students must obey and respect the instructions of the driver at all times.
2. Student riders must stay seated at all times while the school transportation is in motion. If seat belts are available, they must be worn at all times by students while the transportation is in motion.
3. Students may not move from their seats until the transportation has come to a complete stop.
4. Students' actions should not cause the driver to be distracted while the transportation is moving.
5. Students should not talk in an overly loud voice, scream, or yell on the transportation. They may talk quietly with a neighbor.
6. There is to be no profanity or vulgar language or gestures on the transportation.
7. All body parts (head, arms, long hair, etc.) must be kept inside of the transportation.
8. There is to be no writing on or destruction of property.
9. There is to be no bullying, threatening, or sexual harassment of others.
10. There is to be no throwing of any object within the transportation or out of the windows of the transportation.
11. There is to be no wrestling, spitting, fighting, pushing, and/or shoving.
12. The transportation driver may assign seats.
13. Objects that may be harmful, e.g., sharp metal objects and weapons, are prohibited.
14. Smoking is prohibited on the transportation at all times.
15. The driver will report misbehavior to the appropriate school administrator.

I give permission for my scholar to ride in Hope Community Public Charter School's 15 passenger van and/or school provided contracted transportation to travel to extracurricular athletic and club meetings, practices, games, and events. Furthermore, I and my scholar have read, understood, and accepted the above transportation policy.

Parent Signature: Date:

HOPE COMMUNITY PCS
2917 8th St NE, Washington, DC 20017 | 202.832.7370 | HopeTolson.org

# 2024-2025 Non- Consent Student Media Consent and Release Form

**(Only complete and return to your child's teacher if you do not give consent)**

Throughout the school year, students may be highlighted in efforts to promote Hope Community Public Charter School activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of our schools through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media.

a. This is with the understanding that neither HCPCS nor its representatives will reproduce said photograph, interview, or likeness for any commercial value or receive monetary gain for use of any reproduction/broadcast of said photograph or likeness. I am also fully aware that I will not receive monetary compensation for my child's participation.

b. I further release and relieve HCPCS, its Board of Trustees, employees, and other representatives from any liabilities, known or unknown, arising out of the use of this material. I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions. Please understand that failure to return this release form will constitute approval of the above requests.

Please Print Name of child _____Grade_____

Address _____

City, State, Zip_____

Signature of Parent or Guardian _____

# Student Meals Form (25-26 SY)

Hope Community PCS has partnered with Whitson's Culinary Group to provide healthy and nutritious USDA-approved breakfast and lunch to all students.

Our meal program is **FREE** for all registered students at Hope Community PCS. In order to participate, please complete the student meal form below to ensure the preferred meals are ordered for your child each day. If your child has any dietary restrictions, please indicate that here and attach your completed medical substitution form.

If you have any questions or concerns, please email our school operations team at operations@hopetolson.org.

Student's Full Name:_____ Grade Level (25-26 SY): _____

- ☐ NO - My child will NOT participate in Hope's free student meals program.
- ☐ Yes - My child will participate in Hope's free student meals program.

  Please select your child's meal type:

  - ☐ Regular
  - ☐ Vegetarian
  - ☐ Dairy-Free

Does your child have any known allergies? If Yes, please list:

_____

_____

Parent Name (print):_____

Parent Signature: _____

Today's Date: _____

# Medical Dietary Accommodation Form

Please complete this form if your student requires a special meal plan, related to a medical condition or food allergy. A new form must be submitted each time a dietary change is requested. The school will contact you to discuss menu options. Please note that **this form requires a Medical Practitioner's signature.**

**Section A - Must be completed by the Parent/Guardian**

Name of Student _____ Grade _____

Teacher's Name _____

Does your student typically eat school provided meals? ☐ Yes ☐ No

If yes, which meals will your child eat? ☐ Breakfast ☐ Lunch

Which days will your child most likely eat lunch at school? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

**I certify that the above-named student needs special school food as described on this form:**

Parent/Guardian Name (printed)_____

Signature_____ Phone Number_____

Email Address_____ Date_____

**Section B - Must be completed by the Medical Practitioner**

Does the student have food allergies? ☐ Yes ☐ No

If yes, please select the allergen from the list below

**Wheat**
☐ All Wheat

**Tree Nuts (not provided at the school)**
☐ All Tree Nuts

**Eggs**
☐ All Egg Proteins- albumin (white) and Yolk
☐ Whole Egg- hard boiled and scrambled
☐ Eggs baked in products are ok (i.e. pancakes)

**Peanuts (not provided at the school)**
☐ All Peanuts

# Medical Dietary Accommodation Form

**Soy**
☐ All Soy Protein
☐ All Soy Protein, except Soybean Oil

**Dairy**
☐ All Milk Proteins- Casein, Whey, etc.
☐ Fluid Milk
☐ Cheese
☐ Yogurt

**Fish**
☐ All Fish

**Shellfish**
☐ All Shellfish

**Other:** _____

**Specific Foods to Omit or Substitute:**

_____

_____

**Section C - Must be completed by the Medical Practitioner**

Does the student require special modification of dietary textures? ☐ Yes ☐ No

Indicate texture on prescribed special diet.

☐ **Chopped** (please indicate any specific instructions)

_____

☐ **Ground** (please indicate any specific instructions)

_____

☐ **Pureed** (please indicate any specific instructions)

_____

# Medical Dietary Accommodation Form

**Section D - Must be completed by the Medical Practitioner**

Does the student have other special nutritional or feeding needs? ☐ **Yes** ☐ **No**

Please describe the special diet/feeding needs such as celiac disease, diabetes, etc.

_____

_____

_____

**I certify that the above-named student needs special school food as described above.**

**Office Name: _____ Phone Number:_____**

**Medical Practitioner's Name: _____ Date:_____**

**Medical Practitioner's Signature: _____**

*The information in this form may be shared with pertinent food-service management vendor staff to properly accommodate your student unless otherwise specified in writing. Accommodations may be discontinued via written request from the parent/guardian.*

# Student Food Allergy Disclosure

If your child has a food allergy that you would like to disclose, please complete this form and return promptly after enrollment or after the start of school. **Note that medical authorization/action plan (Medical Dietary Accommodation Form) will need to be completed by a physician and submitted separately to the school nurse**.

Student Name: _____ Grade _____

- ☐ My child **does not** have any known food allergies
- ☐ My child **has** the following food allergies that the District should be made aware of:

| Food Name: | Nature of the Allergic Reaction: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I understand that since I am providing this information without documentation of a food allergy from a physician, this information will **NOT** be included in my child's health record. Once I have the required physician's documentation of my child's food allergy(ies), I will submit it to the school so that the information may be included in my child's health record.

Parent Name (Please Print)_____ Date _____

Parent Signature _____

*Reviewed 12/2024*

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

# HOME LANGUAGE SURVEY INSTRUCTIONS FOR LEAS

**PURPOSE:** The Home Language Survey is used to determine if the student is eligible to take an English language proficiency screener. The screener score determines if the student is identified as an English learner or not an English learner. Students who are identified as English learners have the right to participate in the English language instructional program at school. **Federal law[1] requires schools to offer eligible students an English language instructional program so they may attain English language proficiency and achieve academic success.**

The Home Language Survey is **not** used to determine a family's immigration status; a family's residency status; or if the student is an English learner (this is determined by the English language proficiency screener).

## HOW TO ADMINISTER THE SURVEY

- Provide **all** families enrolling their child in a District of Columbia school for the **first** time the OSSE Home Language Survey. The form is in English, Spanish, Amharic, French, Chinese, Korean and Vietnamese.
    - **For LEAs that provide the Home Language Survey within their online enrollment form,** be sure to provide the information for families in the grey box and the questions exactly as stated, including the translations into English, Spanish, Amharic, French, Chinese, Korean and Vietnamese.
    - **For re-enrolling students or students transferring within DC,** check the Early Access to English Learner Data application to verify the student's EL status and previous screening and/or ACCESS scores. It is **not** necessary to give this survey to families who are *re*-enrolling their child in a District of Columbia school.
- Reasonable efforts should be made to help the family understand the purpose of the survey and how to complete it. If needed, provide language support to families who may not be able to read or understand it.
    - Skilled interpreters should be made available for families who need language assistance to complete the survey[2]. This includes who are illiterate, need sign language, and/or need braille.
    - The Language Line, a telephonic interpreting service where an interpreter participates in the conversation between the school and the family over the telephone, is one resource schools can use.
- Ensure the survey has been completed, signed, and dated by the parent or guardian.
- A school official, such as the registrar, must sign and date the bottom of the form upon receipt from the parent or guardian.
- Keep the signed and dated survey in the student's file.
- If a family refuses to complete the survey, make a reasonable effort to help the family understand the purpose of the survey and how to complete it; including providing language assistance, if necessary. If, after reasonable efforts have been made, the family still refuses to complete the survey, note the refusal and date on the survey and do not flag the student for English language proficiency screening.

## HOW TO PROCESS THE HOME LANGUAGE SURVEY RESPONSES

- If the response to question 1, 2 or 3 is a language other than English, refer the student to the appropriate LEA staff, e.g., English learner coordinator, for English language proficiency screening.
- The screener must be administered within 30 days of the student's first day attending the school (Stage 5 enrollment). OSSE's *Delivering Education Services to English Learners* lists state-approved screeners.
- If the response to questions 1, 2 and 3 is English only, the student is considered proficient and does not need to be screened.
- The fourth question "For additional information only: What other languages are spoken in your home?" must not be used to determine screening. It is included to provide the school additional information about the student and family's multilingual assets.
- Enter the language(s) listed on questions 1 and/or 2 in your LEA's School Information System (SIS) under the "native language" field. The language entered must correspond to the three-digit code for a valid language on the International Organization of Standardization list (www.iso.org).

1 ESSA sec. 1112 requires local education agencies using Title I or Title III funds to provide a language instruction educational program and not later than 30 days into the school year, inform parents of an English learner identified for participation or participating in such a program.
2 Refer to Delivering Educational Services to English Learners and the Office of Human Rights website for more information about the Language Access Act, covered entities and resources.

District of Columbia
Office of the State Superintendent of Education

# 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

District of Columbia
Office of the State Superintendent of Education

# ENCUESTA DEL IDIOMA EN EL HOGAR

Como parte del proceso de inscripción en las escuelas públicas y escuelas públicas chárter del DC, todos los padres/madres y tutores deben completar la Encuesta del idioma en el hogar. En el momento de la inscripción, los padres/madres deben completar la Encuesta del idioma en el hogar de OSSE para todos los estudiantes que vayan a inscribirse en una escuela del DC por primera vez. El propósito de las tres preguntas a continuación es determinar si su hijo(a) necesita ser evaluado en su competencia del idioma inglés. Si en las respuestas a las preguntas 1, 2 o 3 se indica un idioma diferente al inglés, la escuela debe evaluar a su hijo(a) mediante un examen para identificar si debe ser un aprendiz de inglés.

**Todos los habitantes del DC, sin importar sus antecedentes, son bienvenidos en las escuelas públicas del Distrito de Columbia.**

La Encuesta del idioma en el hogar ***no*** se usa con propósitos migratorios y no se comparte con el Servicio de Inmigración y Control de Aduanas (ICE, en inglés). La Encuesta del idioma en el hogar ***no*** se usa para determinar:

- su estatus migratorio;
- su estado de residencia; ni
- si su hijo(a) es un aprendiz de inglés.

Por favor, avísele a su escuela si necesita ayuda para completar la Encuesta del idioma en el hogar.

Este formulario debe ser firmado y fechado tanto por el padre/madre/tutor como por el encargado de la escuela y debe ser guardado en el archivo del estudiante.

Apellido del estudiante

Nombre del estudiante

Nombre de la escuela

**1. ¿Cuál es el idioma que principalmente hablan en el hogar?**

**2. ¿En qué idioma habla con más frecuencia el estudiante?**

**3. ¿Cuál fue el primer idioma o idiomas que aprendió el estudiante?**

Solo para información adicional:
**¿Qué otros idiomas se hablan en su hogar?**

Firma del padre/madre/tutor

Fecha

Firma del encargado de la escuela

Fecha

Para ser completado por el encargado de la escuela:
**¿Debe ser remitido para evaluación preliminar de competencia en el idioma inglés?** ☐ Sí ☐ No