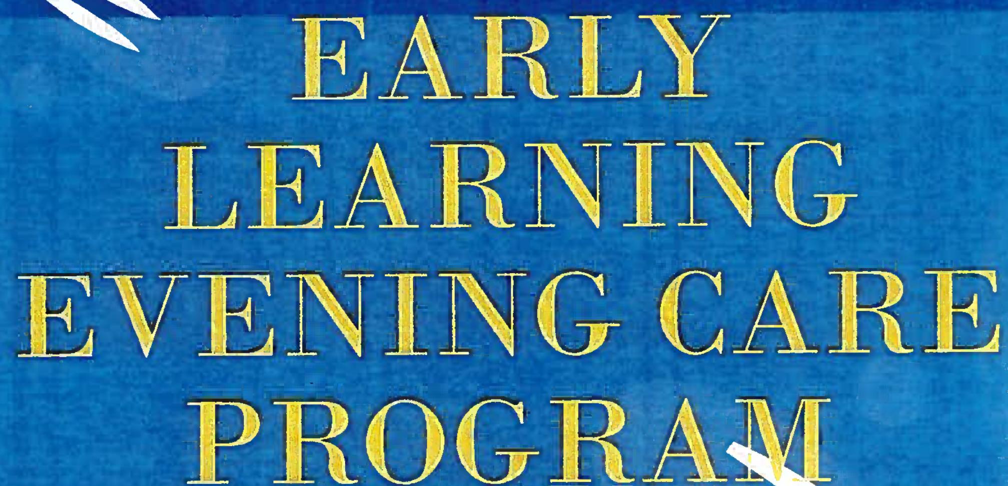
Bright Beginnings don't always
start at sunrise!


EARLY
LEARNING
EVENING CARE
PROGRAM

The solution to non-traditional childcare

Early Learning Evening Care Program

Hours of Operation: 3:30-11:00pm *(Start hour restrictions apply.)
*Accepts DHS Non-Traditional Vouchers (call: 202-727-0284) **or** $40/per day

The following documents are needed to complete your application:

- ☐ Social Security Cards for all children and parent(s)
- ☐ Birth Certificates for all children (with parent's name listed)
- ☐ Insurance Cards for all children and parent(s)
- ☐ Photo ID
- ☐ Current DC Health Certificate for each child enrolling (must be within 1 year)
- ☐ Current DC Dental Certificate for each child enrolling (3 years of age and above)
- ☐ If Homeless Veteran, please provide proof of military activity (military I.D., military paperwork)
- ☐ Proof of Income
- ☐ Proof of Residence:
    1. Lease signed within 30 days; or
    2. Notarized letter within 30 days, with 2 pieces of mail; or
    3. Letter from Shelter/Housing Program on letterhead stating address and name of all children residing within 30 days; or
    4. Official rent receipt within 30 days; or
    5. Original utility bill/telephone bill within 30 days (cell phone bill not applicable)
- ☐ Proof of Work/Training/Educational activities:
    1. If working:
        - A letter from your employer on letterhead stating: the start date, number of hours per week, wage per hour, and your schedule

        OR
        - Three consecutive pay stubs (you must be working at least 20 hrs per week) and Work Schedule (weekly, bi-weekly, or monthly depending on place of employment)
    2. If in training:
        - A letter of acceptance into the training program on letterhead and your training schedule (Must be enrolled at least 20 hrs per week)
    3. If in educational activities:
        - A class schedule (Must be enrolled at least 20 hrs per week)

**We accept children with disabilities or suspected disabilities. Parents and/or guardians are encouraged to provide information about their child's specific disabilities

If you have any questions about where to obtain the above items, or to schedule an intake appointment, please contact:

Valerie Flemings
Early Learning Evening Care Coordinator
202-842-9090 ext. 102
vflemings@brightbeginningsinc.org

Bright Beginnings, Inc. accept children with disabilities, pregnant homeless women and homeless veteran families. Directly serviced by the P6/96 Metro Bus Lines and walking distance from New York Avenue and Mt. Vernon/ Convention Center Metro Rail Stations

Early Learning Evening Care Program

Application for Enrollment

Child's Name:______________________________ Date of Birth:___________ Sex:_____ Age:______

Parent/Guardian's Name(s):____

Place of Employment, Class, Training:____________________________________

Work/School Phone:_________________________

Home Address:____
(Street) (City) (State) (Zip Code)

Home Phone:________________________ Cell Phone:_____________________

Social Security No.(Child)____________ Social Security No. (Parent)____________

Are you or your spouse a Homeless Veteran: Yes _____ No ______

Branch:__________ Rake at time of Discharge:____________

Do you have a Non-traditional DHS Voucher: Yes__________ No__________

Hours of Operation are 3:30pm until 11:00pm, Monday through Friday. **Infant (6weeks-12months) Hours of Operation are from 4:00pm-11:00pm.**

Child's Medical Coverage:_________________ Insurance No.:_________________________

Other members of child's household:

____
Name Relationship to child Age

____
Name Relationship to child Age

____
Name Relationship to child Age

____
Name Relationship to child Age

Has your child ever attended a preschool or daycare program before?:_____________

If yes, where:_____________________ How long?:__________________________

Parent/Guardian Signature____

The cost of the Early Learning Evening Care program is $40.00 per day. Weekly payment is due in advance. Eligible families may use DHS non-traditional childcare vouchers to cover program fee.

128 M Street, N.W. • Washington, DC 20001 • Ph: 202.842.9090 • Fax: 202.842.9095 • www.BrightBeginningsInc.org

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐M ☐F	Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other____
Parent or Guardian Name:	Telephone: ☐Home ☐Cell ☐Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other____		Primary Care Provider (PCP):	

Part 2: Child's Health History, Examination & Recommendations

Health Provider: Form must be fully completed.

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: ___/___ (>3 yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)____ %____
HGB / HCT (Required for Head Start)	Vision Screening Right 20/____ Left 20/____	☐ Glasses ☐ Referred	Hearing Screening Pass____ Fail____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

______

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: ______

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

______

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If TST Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	Health Provider: POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	Health Provider: *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO **This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.**

☐ YES ☐ NO **This athlete is cleared for competitive sports.**

☐ YES ☐ NO **Age-appropriate health screening requirements performed within current year. If no, please explain:**

______

Print Name			
Address	MD/NP Signature		Date
		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name	Signature	Date

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

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

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

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

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

Signature of Medical Provider ____________________ Print Name or Stamp ____________________ Date __________

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

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

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

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

Reason: ____

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

Signature of Medical Provider ____________________ Print Name or Stamp ____________________ Date __________

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

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

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

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

Signature of Medical Provider ____________________ Print Name or Stamp ____________________ Date __________

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender: ☐ M ☐ F	School or Child Care facility:
Parent/Guardian Name	Telephone1: ☐ Home ☐ Cell ☐ Work	Home Address:		Wan
Emergency Contact:	Telephone2: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zip code:

Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other________

Primary Care Provider (Medical):	Dentist/Dental Provider:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other________

Part 2. Child's Clinical Examination (to be completed by the Dental Provider) Date of Exam ________

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 ____	17 ____	A ____	K ____
2 ____	18 ____	B ____	L ____
3 ____	19 ____	C ____	M ____
4 ____	20 ____	D ____	N ____
5 ____	21 ____	E ____	O ____
6 ____	22 ____	F ____	P ____
7 ____	23 ____	G ____	Q ____
8 ____	24 ____	H ____	R ____
9 ____	25 ____	I ____	S ____
10 ____	26 ____	J ____	T ____
11 ____	27 ____		
12 ____	28 ____		
13 ____	29 ____		
14 ____	30 ____		
15 ____	31 ____		
16 ____	32 ____		

Key (Check Appropriate)

- S - Sealants
- X - Missing teeth
- ● Restoration
- || Non-restorable/ Extractic
- 1D-One surface decay
- UE- Unerupted Tooth
- 2D-Two surface decay
- 3D-Three surface decay
- 4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings		Comments
1. Gingival Inflammation	Y	N	
2. Plaque and/or Calculus	Y	N	
3. Abnormal Gingival Attachments	Y	N	
4. Malocclusion	Y	N	
5. Other (e.g. cleft lip/palate)			

Preventive services completed ☐ Yes ☐ No

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐ is complete. ☐ is incomplete. Referred to

DDS/DMD Signature	Print Name	Date
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department oi Health

PRINT NAME of parent or guardian

SIGNATURE of parent or guardian | Date