ROCKETSHIP
PUBLIC SCHOOLS

Enrollment Requirements Checklist

Welcome to Rocketship Public Schools! To enroll your child(ren), complete the following documents. Online registration is available.

- ▢ **Student Information** (Page 2)
- ▢ **Child Find Query & Health Form** (Page 3)
- ▢ **Home Language Survey & Media Release** (Page 5)
- ▢ **Other Information & Emergency Contacts** (Page 6)
- ▢ **Request for Student Records** (Page 7)
- ▢ **Appletree Consent Forms - PreK only** (Page 8)

Registration is not considered complete until the following mandatory documents are received.

- ▢ **Birth certificate, Baptismal Certificate, Passport, or Hospital Record**.
  If the document does not contain the parent/guardian name, additional guardianship verification is required. Some examples of verification include:
  - Adoption decree
  - Court order of legal guardianship/custody
  - Letter of documentation from the Department of Human Services indicating guardianship
  - Letter of documentation of foster care placement
- ▢ **Current photo ID** (to verify identity, not residency)
  Examples include DC driver's license or identification card, valid passport, consulate-issued photo identification, military identification, or other government-issued photo identification.
- ▢ **DC Universal Health Certificate Form** (included in this packet)
- ▢ **DC Oral Health Assessment Form** (included in this packet)
- ▢ **My School DC Seat Acceptance Form** (issued after enrollment offer is accepted)
- ▢ **DC Residency Verification Form (DCRV)** (included in this packet)
- ▢ **Proof of DC Residence**
  EITHER One of the following with same enrolling person name and address on DCRV:
  - Pay stub within 45 days of enrollment date
  - Unexpired documentation of DC Government financial assistance
  - Certified copy of DC Tax Form-D40
  - Military housing orders
  - Embassy letter

  OR Two of the following items with the same enrolling person name and address on DCRV:
  - Unexpired DC motor vehicle registration.
  - Unexpired DC driver's license or non-driver ID.
  - Unexpired rental/lease agreement and proof of payment
  - Utility bill within 60 days of enrollment date and proof of payment

Additional documentation (if applicable)

- ▢ **Most recent Individualized Education Plan (IEP) or 504 Plan**
- ▢ **Medication Administration Form** (included in this packet)
- ▢ **Physician Food Allergy Accommodation form** (included in this packet)
- ▢ **Withdrawal Form** (from previous school with transcript that shows current grade level)

ROCKETSHIP
PUBLIC SCHOOLS

DC: 2024-2025 New Student Registration Form

Student Information

Student's Name: _____
Legal Last Name *Legal First Name* *Middle Name*

Student Date of Birth: _____ **Gender:** ▫ Female ▫ Male ▫ Non-Binary 2024-24 Grade Level_____
Month / Day / Year

Student's Primary Home Address*: _____
* location where student sleeps each night *Street , Apt. #, City, Zip Code*

Student lives with: ▫ Mother ▫ Father ▫ Both Parents ▫ Legal Guardian ▫ Other: _____

Previous School Attended: _____ **Previous School District:** _____

Parent/Guardian Information 1

Parent/Guardian Name: _____ **Relation:** ▫ Mother ▫ Father ▫ Other: _____
Legal Last Name *Legal First Name*

Phone Number: _____ **Email:** _____ **Parent Communication** ▫ English ▫ Spanish ▫ Vietnamese ▫ Other

Parent/Guardian Information 2

Parent/Guardian Name:_____ **Relation:** ▫ Mother ▫ Father ▫ Other: _____
Legal Last Name *Legal First Name*

Phone Number: _____ **Email:** _____ **Parent Communication** ▫ English ▫ Spanish ▫ Vietnamese ▫ Other

Address (*if different from above*) _____
Street, Apt. #, City, Zip Code

Additional Student Demographics

Student Ethnicity: Is the student Hispanic/Latino? ▫ Yes, Hispanic or Latino ▫ No, not Hispanic or Latino

Student Race (Ethnicity is different from race. A student race must be selected. If two or more races, check all that apply.):
▫ American indian or Alaska Native ▫ Asian ▫ Black or African American ▫ Pacific Islander or Native Hawaiian ▫ White

Student/Family Address Type: ▫ Single Family *(House, Apartment, Condo, Mobile Home)* ▫ Doubled-Up *(Living with extended family or friend due to loss of housing)* ▫ Hotel/Motel ▫ Unsheltered *(Car/Campsite)* ▫ Shelter *(Transitional Housing Program)*

I have reviewed this document and to the best of my knowledge, the information above is true and complete. The undersigned declares under penalty of perjury that they are the parents of legal guardians of the above-named student and grant the above authorizations.

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

ROCKETSHIP
PUBLIC SCHOOLS

Child Query and Health Form

Child Query and Screening Consent

Student's Name: _____ **Student Date of Birth:** _____
Legal Last Name *Legal First Name* *Month / Day / Year*

Does your child have an active Individualized Education Program (IEP)?
▢ Yes ▢ No **If yes, please provide a copy*

Does your child have a recent evaluation that was completed for possible special education services?
▢ Yes ▢ No **If yes, please provide a copy*

Does your child have a 504 Plan?
▢ Yes ▢ No **If yes, please provide a copy*

Does your child receive speech/language services?
▢ Yes ▢ No **If yes, please provide a copy*

Did your child receive special education services when he/she was enrolled in his/her previous home/private school?
▢ Yes ▢ No

Are you concerned that your child has a disability that impacts Student academically or impacts the safety of Student while on campus?
If yes to any of the questions above, please provide additional details:_____

_____

_____

Do you have any additional concerns you'd like to share? ▢ Yes ▢ No

If yes, please explain: _____

_____

_____

Please provide all copies of Special Education section upon enrollment

Rocketship Public Schools will be providing vision and hearing screenings to students during the school year. These screenings will be conducted during the school day. The results of the screenings will be sent home for you to review. These screenings do not replace the regular vision screenings provided by your child's health care provider. Do you give your consent for your child to participate in these screenings?

☐ **YES:** I **DO** GIVE PERMISSION for my child to be screened.

☐ **NO:** I **DO NOT** GIVE PERMISSION for my child to be screened.

ROCKETSHIP
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Student Health Information

DC Universal Health Certificate Examination Date: _____ **(Please provide school with a copy of the certificate)**

DC Oral Health Assessment Date: _____ **(Please provide school with a copy of the form)**

Student Physician: _____ **Physician Phone:** _____

Student Dentist: _____ **Dentist Phone:** _____

Covered by Medicaid? ☐ Yes ☐ No If Yes, Medicaid Number: _____

Health Insurance Provider: _____

Student Health Insurance? ☐ Yes ☐ No If Yes, Group ID#: _____ Medical# _____

Does the student experience any of the following:

Allergies? ▫ Yes ▫ No **Asthma?** ▫ Yes ▫ No **Diabetes?** ▫ Yes ▫ No **Seizures?** ▫ Yes ▫ No

Vision Problem? ▫ Yes ▫ No **Hearing Problem?** ▫ Yes ▫ No **Heart Condition?** ▫ Yes ▫ No **Uses Glasses?** ▫ Yes ▫ No

Breathing Problem? ▫ Yes ▫ No **Physical Limitations?** ▫ Yes ▫ No **Other?** ▫ Yes ▫ No
*due to bee stings

If yes to any of the questions above, please provide additional details: _____

_____

_____

Food Allergies or Dietary Restrictions? If yes, please provide a copy from doctor _____

_____

Is medication required at school? ▫ Yes ▫ No **** if yes, please provide the "OSSE Medical Administration Form" signed by the physician***

Medication #1: _____ Diagnosis: _____ Taken at school: ☐ Yes ☐No

Medication #2: _____ Diagnosis: _____ Taken at school: ☐ Yes ☐No

Medication #3: _____ Diagnosis: _____ Taken at school: ☐ Yes ☐No

I / We the undersigned declare under penalty of perjury that we are the parents or legal guardians of the above-named student and grant the above authorization.

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

ROCKETSHIP
PUBLIC SCHOOLS

Home Language Survey & Media Release

Home Language Survey

Student's Name: _____ **Student Date of Birth:** _____
Legal Last Name *Legal First Name* *Month / Day / Year*

Directions to Parents and Guardians:

The U.S. Department of Education directs schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please do not leave any question unanswered on the "OSSE Home Language Survey."

Media Release

Rocketship Public Schools is proud of the many accomplishments of our students and staff. Often, such accomplishments draw the attention of RPS partners, newspapers, television stations, or other media who visit our schools to photograph, videotape, record, and/or interview students and staff during various activities. In addition, we often use pictures of our students in Rocketship Public Schools publications and websites. Our education partners may also want to use student pictures and recordings for similar educational and promotional purposes. In furtherance of our goal to develop exceptional educators, we may invite educational partners (e.g., teacher credentialing organizations) to attend classroom sessions and share classroom photos and videos with these organizations to support our educators' professional development.

For your child's privacy, we must know whether or not you want your child to be photographed, videotaped, or interviewed for the purposes described above. .

▢ **Yes, I DO give permission** for my child to be photographed, videotaped, or interviewed by the news and/or media for any reason and for Rocketship Public Schools to use my child's photograph, name, words and work product in school and Rocketship Public Schools publications, websites, and other marketing materials. or Rocketship Public Schools and its licensees (e.g., third-party educational support organizations and partners)—collectively "Rocketship".-Further, I authorize Rocketship to record my child's likeness and/or voice with still photography, film, videotape, or digital recording ("Recordings") and to edit such Recordings, and to use, reproduce, display, and/or distribute, and/or to make derivative works from any of the Recordings or my child's work product for educational and promotional purposes, in perpetuity. I understand and agree that use of such Recordings and work products will be without any compensation to me or my child. I understand and agree that Rocketship may display or otherwise use my child's first and last name in conjunction with its use of the Recordings and/or my child's work product. I understand and agree that Rocketship and/or its authorized representatives shall have the exclusive right, title, and interest, including copyright, in the Recordings.

▢ **No, I DO NOT give permission** for my child to be photographed, videotaped, or interviewed as described above. Nor do I give my permission for Rocketship Public Schools to use my child's Recordings for the purposes described above.

I / We the undersigned declare under penalty of perjury that we are the parents or legal guardians of the above-named student and grant the above authorizations.

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

ROCKETSHIP
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Other Parent and Student Information

Additional Parent/Guardian and Student Information

Student's Name:_____ **Student Date of Birth:** _____
Legal Last Name *Legal First Name* *Month / Day / Year*

Is there a legal custody agreement regarding this student? ▢ Yes ▢ No
If YES, what type? ▢ Sole Custody ▢ Joint Custody ▢ Guardian ▢ Foster/Group Home **If yes, please provide documents*

Have you or a member of your family within the past 36 months relocated with the intent to obtain seasonal or temporary employment in agriculture, fishing, and dairy food processing?
▢ **Yes**, ▢ **No**

Parent/Guardian In Military | Please indicate if either parent/guardian is a member of the armed forces
Is either parent or guardian on active duty in the military?
▢ Yes ▢ No
Is either parent or guardian a traditional member of the Guard or Reserve?
▢ Yes ▢ No
Is either parent or guardian a member of the Active Guard/Reserve (AGR) under Title 10 or full time National Guard under Title 32?
▢ Yes ▢ No

Are you interested in your child participating in the Prepared for Liftoff program? (See page 11 for 5th graders only)
▢ **Yes** ▢ **No**

Student Emergency Contact Information

Please enter the name of the authorized contacts and their relationship to the student. DO NOT enter Parent/Guardians here if you have already entered in the Parent/Guardian section in the New Student Registration Form.

Emergency Contact 1 **required*

Last Name:	*First Name:*	*Relationship: to Student*	*Phone:*

Emergency Contact 2

Last Name:	*First Name:*	*Relationship: to Student*	*Phone:*

Emergency Contact 3

Last Name:	*First Name:*	*Relationship: to Student*	*Phone:*

Emergency Contact 4

Last Name:	*First Name:*	*Relationship: to Student*	*Phone:*

I / We the undersigned declare under penalty of perjury that we are the parents or legal guardians of the above-named student and grant the above authorizations.

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

ROCKETSHIP
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Request for Student Records

Student Request Form

This form is required of all students who will be entering grades K- 5. Please send all records and files for the following student and include all health records, test scores, portfolios, and confidential files.

Student's Last, First Name _____ **Student Birth Date** ***(Mo/Day/Year)*****:** _____

Previous School Attended: _____ **Previous School District:** _____

2022-23 Grade Level: _____

Send records to the school marked below to the attention of "Student Records":

▢ **Rocketship Rise Academy**
2335 Raynolds Place SE
Washington, DC 20020
Phone: 202-750-7177
Email: rise@rsed.org

▢ **Rocketship Legacy Prep**
4250 Massachusetts Avenue SE
Washington, DC 20019
Phone: 202-803-7004
Email: dcinfo@rsed.org

▢ **Rocketship Infinity Community Prep**
5450 3rd Street NE.
Washington, DC 20011
Phone: 202-627-2256
Email: dcinfo@rsed.org

I (parent(s)/legal guardian(s) hereby consent and authorize the release of my student(s) records as requested above by the school I've marked above

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

ROCKETSHIP
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Appletree Field Trip Permission

Throughout the school year, teachers will be taking their students on educational field trips that relate to the instructional areas being studied. These trips not only extend learning outside the classroom, but are special social times for the classes as well. AppleTree Early Learning Public Charter School field trips are well planned, approved by school leaders, and appropriately supervised by our staff with support from parent volunteers.

We request written permission from you in order for your child to participate in all class field trips throughout the 2019-2020 school year. Rather than ask you to give written permission each time a field trip is scheduled, we ask that you give your written permission for all field trips planned for the school year. Prior to each trip, teachers will send notification including destination, focus of trip, travel arrangements, appropriate dress, information about meals and information regarding any monies needed for the trip.

We also ask you to grant your permission for your child to take walks in the surrounding area of the school for the purposes including, but not limited to: physical fitness, parks for educational/recreational purposes, and/or local field trips. Permission also includes visits to local libraries and other educational venues as part of the normal school day.

Granting prior permission will allow your child to participate fully in all of our important off-campus learning experiences.

Thank you for your support,

Sincerely,

The AppleTree Team

This student has my permission to participate in all field trips sponsored by AppleTree Early Learning Public Charter School.

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

ROCKETSHIP
PUBLIC SCHOOLS

Appletree Every Child Ready

Dear Parent,

The purpose of **Every Child Ready** is to create high quality curriculum and professional development resources for other preschools. We hope that these resources will allow children in other programs the opportunity to experience a high quality preschool program.

Through **Every Child Ready**, your child's classroom will receive additional books and literacy related materials and your child's teacher will receive curriculum materials and training. If you participate, **you may also receive books and materials that will help you support your child's learning at home**.

In order for your child to take part in this important project, we are asking you to give AppleTree project staff permission:

1. For my child's assessment results and findings to be shared with my child's teacher, other School staff, consultants, educators, AppleTree, and appropriate regulatory authorities, including the District of Columbia Public Charter School Board.

2. To videotape and photograph your child in his/her class. Videotape and photographs may be shared with your child's teacher, project staff, consultants, other educators and the public. Videotapes and photographs may be included in later curriculum and professional development products that will be commercially published and widely distributed to improve teaching and learning for all children. In the course of filming normal instruction, the teacher may use your child's first name. No other identifiable information will be disclosed regarding your child.

3. To talk with your child's teachers and other school personnel about your child's learning.

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

ROCKETSHIP
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Appletree Photography and Video Release

AppleTree Schools reserves the right to photograph/videotape its students, faculty, staff and facilities in connection with the activities of the school and to reproduce such images to promote, publicize, or explain the school or its activities. This includes the right, without limitation, to publish such images in the school newsletter, and PR/promotional materials such as marketing and admissions publications, advertisements, fundraising material, and any other school-related publication. These images may appear in any of a variety of formats and media now available or that may be available in the future, including but not limited to print, broadcast, videotape, and electronic/online media.

AppleTree Schools is in partnership with AppleTree Institute. As part of the regular program, your child's teachers will assess your child's academic and social skills. AppleTree Institute reviews the data internally and with your child's teacher to improve instruction. De-identified data are also shared with staff, consultants, educators, and in educational reports. Within this partnership, AppleTree Institute reserves the right to photograph/videotape students, faculty, staff and facilities in connection with the activities of the school and to reproduce such images to promote, publicize, or explain the school or its activities. These images may appear in any of a variety of formats and media now available or that may be available in the future, including but not limited to print, broadcast, videotape, and electronic/online media.

Please select your answer

▫ **Yes, I DO give my permission** to AppleTree Schools to use images and/or video of my child as indicated above.

▫ **No, I DO NOT give my permission** to AppleTree Schools to use images and/or video of my child as indicated above.

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

Appletree Consent for Screenings

AppleTree Early Learning Public Charter School will be providing vision and hearing screenings to students during the school year. The Center for Blindness Prevention will provide the vision screenings. These screenings will be conducted during the school day. The results of the screenings will be sent home for you to review. Please contact us if you have any questions. These screenings do not replace the regular vision screenings provided by your child's health care provider.

▫ **Yes, I DO give my permission** for my child to be screened.

▫ **No, I DO NOT give my permission** for my child to be screened.

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

ROCKETSHIP
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Prepared For Liftoff Consent Form

At Rocketship Public Schools DC, our mission is to catalyze transformative change in low-income communities through a scalable and sustainable public school model that propels student achievement, develops exceptional educators, and partners with parents who enable high-quality public schools to thrive in their community. To further this goal for our Rocketship DC alumni, we have assembled a dedicated team of professionals known as the Prepared for Liftoff Transition Team ("PFL") team. PFL is dedicated to partnering with every student and family on the journey to and through Middle School and beyond. The PFL team begins working with Rocketship DC students and families in 5th grade to help them prepare for the transition to middle school.

Throughout middle school, PFL stays connected with students to offer enrollment, wellness, school choice guidance, and a sense of belonging and connection with former Rocketship students and the supportive Rocketship community while in Middle School.

PFL is committed to providing a variety of opportunities for students to prepare for middle school, and the world beyond. In order to provide these available opportunities and supports, Rocketship DC needs your written permission to provide and receive information from your student's educational record with the following types of agencies and institutions: Educational institutions, including the school(s) that the student may attend and the programs that support a student's enrollment in those institutions, attendance, and enrichment programs.

This authorization of disclosure gives consent for

- student attendance and grade information to be released orally or in writing, as preferred by the agency or institution.
- student to have bi-monthly lunch or other gathering with former Rocketship students and staff.
- student to participate in 2 out of school time workshops.
- student to submit 4 surveys per year regarding their health and wellness.

I understand, unless otherwise noted, this authorization of disclosure is valid for the duration of the student's middle school career.

I understand I have the right to revoke authorization at anytime. I, do hereby, declare that I am the legal guardian and I am responsible for the release of information for the student.

Please provide the following information: Student Name:

Student Name	Current Grade	Date of Birth	Current Middle School (if applicable)

Please select one:

☐ I give my permission for student attendance and grade information to be released orally or in writing, as preferred by the agency or institution.

☐ I do not give my permission for student attendance and grade information to be released orally or in writing for the student at this time.

Please select one:

☐ I give my permission for my student to participate in PFL lunches, out of school time workshops, and surveys.

☐ I do not give my permission for my student to participate in PFL lunches, out of school time workshops, and surveys at this time.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

ROCKETSHIP
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Student Technology

CHROMEBOOK USE

Rocketship Public School provides a Chromebook for all students. Beginning Week 4 of school, students in Grade 2-5 will bring Chromebooks between home and school daily. Homework for these grades will be completed on the computer. A charger and case will be provided for transportation between home and school.

- Parents may opt out of bringing the Chromebook home, but must confirm access to a compatible personal computer for homework.

CHROMEBOOK CARE AGREEMENT

Proper handling and care of the Chromebook/Ipad will include all of the following:

A. The user must keep the Chromebook/Ipad in Rocketship Public Schools provided protective case when carrying.
B. Chromebook/IPad and case must remain free of any writing, drawing, stickers, or labels that are not applied by Rocketship Public Schools.
C. Use the Chromebook/IPad on a flat, stable surface. Do not set books and other heavy items on the device.
D. Do not have food or drinks around the Chromebook/ iPad.
E. Wipe surfaces with a clean, dry soft cloth.
F. Avoid touching the screen with pens or pencils.
G. Do not leave the iPad exposed to direct sunlight or near any heat or moisture sources for extended periods of time.
H. It is the user's responsibility to bring their device to school each day fully charged. There will be charging stations at school, but waiting for the device to charge may cause a delay in learning time.
I. The Chromebook/Ipad, case, charger and any additional peripherals are the property of Rocketship PUblic Schools and must be returned when requested by Rocketship Public Schools.
J. Damages to the device should be reported to the Business Operations Manager. Damages will be assessed and may result in a meeting with the guardian and student to review the Chromebook Care policies.
K. If a user has damaged their device, Rocketship Public Schools reserves the right to discontinue sending the device home and will meet with the family to plan how to complete homework.

ONLINE LEARNING PROGRAMS

Rocketship uses Online Learning Programs (OLPs) and Instructional Technology to personalize and supplement learning for all Rocketeers. All programs used by Rocketship Public Schools are FERPA and COPPA compliant. A full list of the programs being used can be found on your school's website. Your child will use OLPs during school hours and for homework. A full list of expectations for daily program usage will be provided by the school.

JETPACKED

Rocketship uses an internally owned software application, JetPackED, to manage and track student completion of Online Learning Programs. The primary guardian listed in the student's registration will be enrolled into bi-weekly updates that will include a Monday SMS/Email highlighting the student's previous week progress and upcoming week's goals, and a Thursday SMS/Email with updated progress towards weekly goals. Texts and emails are one-way. Guardians may unenroll from the weekly texts or emails at any point after receiving the first message by logging into their child's JetPacked portal and updating settings.

ROCKETSHIP
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Technology Agreements

Student's Name: _____ **Student Date of Birth:** _____
Legal Last Name *Legal First Name* *Month / Day / Year*

CHROMEBOOK USE AGREEMENT

- ☐ I agree to the Chromebook Care Agreement:
- ☐ No, I opt out of my child using a school Chromebook at home. I confirm that my child will complete homework using a personal computer that is compatible with all Online Learning Programs

ONLINE LEARNING PROGRAMS AGREEMENT

- ☐ I have read the Online Learning Program agreement

JETPACKED AGREEMENT

- ☐ I have read the JetPacked agreement

I / We the undersigned declare under penalty of perjury that we are the parents or legal guardians of the above-named student and grant the above authorizations.

Parent/Guardian Signature _____ Date _____

Universal Health Certificate

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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

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

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer	
Race: *(check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No		

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

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

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

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

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

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

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

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

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

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

What is the child's risk level for TB?

- ☐ High ➔ *complete skin test and/or Quantiferon test*
- ☐ Low

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

Additional notes on TB test:

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

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

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

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

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

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by:_____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Coronavirus (COVID)	1	2	3	4	5	6	7
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
☐ COVID-19

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

Reason for the medical exemption:_____

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 childcare 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/childcare facility.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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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.

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DC School Immunization Requirements Guide

effective June 2023

This is a summary of vaccines required for children to enter key grades in the District of Columbia. **The number of ✓ is the total number of doses needed to enter those grades.** More detail on the requirements is available at **dchealth.dc.gov/immunizations.**

To start Pre-K3*	To start Kindergarten	To start 7th grade	To start 11th grade
DTaP ✓✓✓✓	DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓
Polio ✓✓✓	Polio ✓✓✓✓	Polio ✓✓✓✓	Polio ✓✓✓✓
Chickenpox ✓	Chickenpox ✓✓	Chickenpox ✓✓	Chickenpox ✓✓
MMR ✓	MMR ✓✓	MMR ✓✓	MMR ✓✓
Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓
Hepatitis A ✓✓	Hepatitis A ✓✓	Hepatitis A ✓✓	Hepatitis A ✓✓
Pneumococcal (PCV) ✓✓✓✓		Tdap ✓	Tdap ✓
Haemophilus Influenzae Type B (Hib) ✓✓✓(✓) *Depending on brand used*		HPV ✓✓	HPV ✓✓
		Meningococcal (ACWY) ✓	Meningococcal (ACWY) ✓✓

✓ = number of doses

***Your Pre-K3 child may become eligible for a booster dose of vaccines against MMR, Chickenpox, Polio, and Diptheria/Tetanus/Pertussis when they turn 4 years of age. We highly encourage getting these on time, however these will not count against the attendance requirement mid-year.**

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Childhood Vaccination Guide

effective 03-01-2022

DC Health recognizes the importance of vaccinations for preventing disease and reducing the dangers that can come with being exposed to certain diseases. This document outlines the vaccine schedule for children based on age. Children are required to be up to date on vaccinations in every grade. More detail on the requirements is available at **dchealth.dc.gov/immunizations.**

Everyone 6 months and older are strongly recommended to receive a COVID-19 and annual flu vaccine

2-3 years old

The following vaccines are typically received before the age of 2:

- 4 doses of Diphtheria/Tetanus/Pertussis (DTaP)
- 3 doses of Polio
- 1 dose Varicella if no history of chickenpox
- 1 dose of Measles/Mumps/Rubella (MMR)
- 3 doses of Hepatitis B
- 2 doses of Hepatitis A
- 3 or 4 doses* of Hib (Haemophilus Influenza Type B)
- 4 doses of PCV (Pneumococcal)

*See PROVIDER for recommended doses.

Your child should receive these vaccine doses upon school enrollment*

4-6 years old

Additional doses needed after receiving the vaccines listed under 2-3 years of age:

- 1 dose of Diphtheria/Tetanus/Pertussis (DTaP)
- 1 dose of Polio
- 1 dose of Varicella if no history of chickenpox
- 1 dose of Measles/Mumps/Rubella (MMR)

7-10 years old

Consult your PROVIDER to be certain your student has received all vaccinations listed under 2-3 and 4-6 years of age.

11-12 years old

Additional Required Vaccines AFTER receiving all vaccines under 2-3 years and 4-6 years.

- 1 dose of Tdap
- 1 dose of Meningococcal (Men ACWY)
- 2 doses of Human Papillomavirus Vaccine (HPV)*

*3 doses of HPV vaccine required if series initiated after 15th birthday

13-15 years

Additional Required Vaccines AFTER receiving all vaccines under 2-3 years, 4-6 years, and 11-12 years.

16+ years old

Additional Required Vaccines AFTER receiving all vaccines under 2-3 years, 4-6 years, and 11-12 years.

- 1 dose of Meningococcal (Men ACWY)

Consult your PROVIDER to be certain your student has received all vaccinations listed under 2-3 years, 4-6 years, and 11-12 years.

***The spacing and number of doses required may vary. Please contact your child's health care provider. For additional information, contact DC Health's Immunization Program at (202) 576-7130.**

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Revised as of March 2024

2024 District Pediatric Vaccine Locations

2201 Shannon Place SE, Washington, DC 20020 | Phone: (202) 576-**7130** | TTY: 71 | Email: doh.immunization@dc.gov

District of Columbia – Pediatric Immunization Locations

By WARD

- WARD 1
- WARD 2
- WARD 3
- WARD 4
- WARD 5
- WARD 6
- WARD 7
- WARD 8

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WARD 1 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 1	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/Self-Pay)
Ahold Giant Pharmacies	1345 Park Road NW 20010	(202) 777-1078	**Mon-Th** 9am-9pm / **Sat** 9am-6pm / **Sun** 10am-5pm	X	✓
Cardozo HS Health Center*	1200 Clifton St NW #C130 20009	(202) 727-5148	**Mon-Fri** 8am-4:30pm	✓	✓
Children's National Columbia Heights	3336 14th St NW 20010	(202) 476-5580	**Mon-Sat** 8am-4pm	✓	✓
Children's National Shaw Metro	641 S Str NW 2nd Fl 20001	(202) 476-2123	**Mon-Fri** 8am-4pm / **Sat** 8am-4:30pm	✓	✓
Community of Hope Marie Reed Health Center	2155 Champlain St NW 20009	(202) 540-9857	**Mon** 8:30am-5pm / **Tues** 8:30am-7pm / **Wed** 8:30am-7:30pm / **Th & Fri** 8:30am-5pm / **Sat** 9am-3:30pm	✓	✓
Howard University Family Practice	2041 Georgia Ave NW #3300 20060	(202) 865-6100	**Mon-Fri** 8:30am-5pm	✓	✓
La Clínica del Pueblo	2831 15th St NW 20009	(202) 462-4788	**Mon-Fri** 10am-4pm	✓	✓
Mary's Center Ontario Road	2333 Ontario Rd 20009	(844) 796-2797	**Mon-Fri** 9am-5pm	✓	✓
Unity Health Care Columbia Heights	1660 Columbia Rd NW 20009	(202) 469-4699	**Mon-Th** 8am-8pm / **Fri** 8am-5pm / **Sat** 8am-Noon	✓	✓
Unity Health Care Upper Cardozo	3020 14th St NW #203 20009	(202) 469-4699	**Mon-Fri** 8am-10pm / **Sat** 8am-2pm	✓	✓

This list is non-exhaustive. Please call or check online for current vaccine availability prior to planning your visit. This list does not include whether an organization has inventory in stock, and whether it is reserved for established patients. School-Based Health Center access is limited to currently enrolled students during the school year.

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WARD 2 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 2	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Ahold Giant Pharmacies	1400 7th St NW 20001	(202) 238-0181	Mon-Th 9am-9pm / Sat 9am-6pm / Sun 10am-5pm	X	✓
Bread for the City	1525 7th St NW 20001	(202) 265-2400	Mon-Th 8:30am-5pm / Fri 8:30am-Noon	✓	✓
Children's Pediatricians & Associates - Foggy Bottom	2021 K St NW #800 20006	(202) 833-4543	Mon-Fri 8am-5pm / Sat 9am-Noon	✓	✓
Michelle Barnes Marshall MD PC	2440 M St NW #317 20037	(202) 775-0051	Mon-Th 9am-5pm / Fri 9am-1pm	✓	✓

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WARD 3 — DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 3	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Georgetown Kids Mobile Medical Clinic/Ronald McDonald Care Mobile	Mobile Clinic	(202) 444-8888	Please Call for Appointments, Days, and Hours	✓	✓
MedStar Georgetown Pediatrics and Gynecology at Tenleytown	4200 Wisconsin Ave NW 4th Floor 20016	(202) 243-3400	**Mon-Th** 8am-7pm / **Fri** 8am-6pm / **Sat** 9am-Noon (by appointment only)	✓	✓

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WARD 4 — DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 4	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Children's National Shepherd Park	7125 13th Place NW 20012	(202) 545-2900	**Mon-Sat** 8am-4pm	✓	✓
District Urgent Care	4903 Georgia Ave NW 20011	(202) 723-0393	**Mon-Fri** 9am-6pm	✓	✓
Mary's Center Georgia Avenue	3912 Georgia Ave NW 20010	(844) 796-2797	**Mon-Fri** 9am-5pm	✓	✓
MedStar Health Roosevelt HS*	4301 13th St NW 20011	(202) 724-4086	**Mon-Fri** 8:30am-4:30pm	✓	✓
Mary's Center SBHC Coolidge HS*	6315 5th St NW 20011	(202) 698-1383	**Mon-Fri** 8:30am-4:30pm	✓	✓
Safeway Pharmacy	3830 Georgia Ave NW 20011	(202) 722-4067	**Mon-Fri** 9am-7pm / **Sat** 10am-4pm (until July 29)	X	✓

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WARD 5 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 5	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Children's National Health Center Pharmacy	111 Michigan Ave NW 20010	(202) 986-1467	**Mon-Fri** 8am-9pm / **Sat & Sun** 10am-6pm	✓	✓
Community of Hope Family Health and Birth Center	2120 Bladensburg Rd NE 20018	(202) 540-9857	**Mon, Wed, Th, & Fri** 8:30am-5pm / **Tues** 8:30am-7:30pm / **Sat** 9am-3:30pm	✓	✓
Cura Capitol Clinical	1140 Varnum St NE #208-B 20017	(202) 930-2380	**Mon-Fri** 8am-5pm / **Sat** 10am-4pm	✓	✓
Dr. Marjorie McKnight / Lisa Banner	106 Irving St NW #2300 20010	(202) 291-6257	**Mon-Fri** 7am-4pm	✓	✓
Mary's Center Fort Totten	100 Gallatin St NE 20011	(202) 847-4387	**Mon-Fri** 9am-5pm	✓	✓
Pediatric Professionals PC	106 Irving St NW #306 20010	(202) 854-0052	**Mon** 7:30am-6pm / **Wed** 8am-4:30pm / **Tues, Th & Fri** 7:30am-5pm / **Sat** 9am-2pm	✓	✓
Providence Family Medicine	1160 Varnum St NE #110 20017	(202) 854-4090	**Mon-Fri** 8am-4pm	✓	✓
The McCuiston Group	106 Irving St NW #218 20010	(202) 291-6257	**Mon-Fri** 7am-4pm	✓	✓
Unity Health Care - Brentwood Square	1251-B Saratoga Ave NE 20018	(202) 832-8818	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm	✓	✓

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WARD 6 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 6	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Children's Pediatricians & Associates – Capitol Hill	650 Pennsylvania Ave SE #C-100 20003	(202) 833-4543	**Mon-Fri** 8am-5pm / **Sat** 9am-Noon	✓	✓
Community Concierge Care – Greenleaf	1200 Delaware Ave SW #3 20024	(202) 888-6440	**Mon-Fri** 9am-5pm	✓	✓
Kaiser Permanente Capitol Hill	700 Second St NE 20002	(202) 346-3000	**Mon-Fri** 9am-5pm	X	✓
Providence Perry Family Health	128 M St NW #50 20001	(202) 854-3840	**Mon-Fri** 8am-5pm	✓	✓
Unity Health Care – Southwest	850 Delaware Ave SW 20024	(202) 469-4699	**Mon-Fri** 8am-5pm	✓	✓
Safeway Pharmacy	415 14th St SE 20003	(202) 920-5870	**Mon-Fri** 8am-8pm / **Sat** 9am-6pm / **Sun** 10am-5pm	✓	✓
Safeway Pharmacy	490 L St NW 20001	(202) 719-2435	**Mon-Fri** 9am-7pm / **Sat** 10am-4pm (until July 29)	X	✓

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WARD 7 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility – Ward 7	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Children's Pediatricians & Associates – Ft. Davis	3839 1/2 Alabama Ave SE 20020	(202) 582-6800	**Mon-Fri** 8am-4pm / **Sat** 8am-Noon	✓	✓
Elaine Ellis Center of Health	1627 Kenilworth Ave NE 20019	(202) 803-2350	**Mon & Wed** 9am-6pm / **Tues & Th** 9:30am-7pm / **Fri** 9:30am-2pm / **Sat (4th of the month)** 9:30am-2pm	✓	✓
Unity – East of the River	4414 Benning Rd NE 20019	(202) 469-4699	**Mon-Fri** 8am-5pm	✓	✓
Unity – Minnesota Ave	3946 Minnesota Ave NE 20019	(202) 469-4699	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm / **Sun (2nd & 4th of the month)** 8am-2pm	✓	✓
Unity – Parkside	765 Kenilworth Terrace NE 20019	(202) 469-4699	**Mon-Fri** 8am-9pm	✓	✓
Unity – Woodson HS SBHC*	540 55th St NE #W101 20019	(202) 469-4699	**Mon-Fri** 8am-4:30pm	✓	✓

This list is non-exhaustive. Please call or check online for current vaccine availability prior to planning your visit. This list does not include whether an organization has inventory in stock, and whether it is reserved for established patients. School-Based Health Center access is limited to currently enrolled students during the school year.

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WARD 8 DISTRICT OF COLUMBIA – PEDIATRIC IMMUNIZATION LOCATIONS

Facility	Address	Phone	Office Hours	Childhood Immunizations (Medicaid Eligible)	Childhood Immunizations (Private/ Self-Pay)
Bread for the City	1700 Good Hope Rd SE 20020	(202) 561-8587	**Mon-Th** 9am-5pm / **Fri** 9am-Noon	✓	✓
Children's Health Center Anacostia	2101 MLK Jr Ave SE 5th Fl 20020	(202) 476-6900	**Mon-Th** 8am-8pm / **Fri & Sat** 8am-4pm	✓	✓
Children's Health Center at THEARC	1801 Mississippi Ave SE 20020	(202) 436-3060	**Mon-Th** 8am-8pm / **Fri & Sat** 8am-4pm	✓	✓
Community of Hope Conway Health and Resource Center	4 Atlantic St SW 20032	(202) 540-9857	**Mon, Tues, Wed, & Fri** 8:30 am-5pm / **Th** 8:30am-7pm / **Sat** 9am-3:30pm	✓	✓
Children's Health Center – Goldberg SBHC Ballou High School*	3401 4th St SE 20032	(202) 645-3843	**Mon-Fri** 8:30am-4:30pm	✓	✓
Core Health & Wellness Center	2516 Sheridan Road SE #A 20020	(202) 610-6103	**Mon-Fri** 9am-3pm / **Sat** 9am-2:30pm	✓	✓
Family and Medical Counseling Service	2041 MLK Jr Ave SE #206 20020	(202) 889-7900	**Mon-Fri** 8am-5pm	✓	✓
MedStar Health – SBHC Anacostia*	1601 16th St SE 20020	(202) 724-5529	**Mon-Fri** 8:30am-4:30pm	✓	✓
Unity Health Care – Anacostia	1500 Galen St SE 20020	(202) 469-4699	**Mon-Fri** 8am-9pm / **Sat** 8am-2pm	✓	✓
Unity Health Care – Stanton Road	3240 Stanton Rd SE 20020	(202) 469-4699	**Mon-Fri** 8am-8pm	✓	✓

This list is non-exhaustive. Please call or check online for current vaccine availability prior to planning your visit. This list does not include whether an organization has inventory in stock, and whether it is reserved for established patients. School-Based Health Center access is limited to currently enrolled students during the school year.