Emmanuel's Children Learning Center

REGISTRATION FORM

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade or Class Level
Emails:			

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address	Cell Phone	Home Phone
Parent	Place Employed	Work Phone
Home Address	Cell Phone	Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached	Address (addresses must be different)	Phone
1.	1.	1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or day care activities.

AGREEMENTS

1. The ECLC agrees to notify the parent(s)/guardian(s) whenever the child becomes ill, and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so, requested by the center.

2. The parent(s)/guardian(s) authorize ECLC to obtain emergency medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately and to assume liability for medical expenses involved. **

3. The parent(s)/guardians agree to inform ECLC within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

4. I agree to return the child to the center with a doctor's note allowing my child to return to school, if my child is seen by a doctor for an illness.

5. I give permission for ECLC to photograph my child and possibly be included in a newspaper article, social media, or ECLC's website. Yes_____ No_____

6. If a child is one hour late in being picked up and emergency contacts cannot be reached the two staff members that will remain with the child will file a Child Protective Services complaint.

7. The parent/guardian gives authorization for ECLC staff to apply Aquaphor, Bag Balm or Destin Extra Strength diaper cream, Coppertone Water Babies hypo-allergenic sunscreen SPF 50 and or insect repellant OFF! Botanicals Deet free, since I am not aware of any adverse reaction. I understand that I may be asked to contribute sunscreen, diaper cream and/or insect repellant for my child that is fully labeled with first and last name. Product expiration checks will be made every spring.

8. _____ I have been given an ECLC parent handbook and I agree to abide by the policies therein.

SIGNATURES

Parent(s) or Guardian(s)_____ ***Date***____ ***Director***_____ ***Date***_____

First Date of Attendance: _____ Last Date of Attendance: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth	**Birth Date**	**Birth Certificate Number**	**Date Issued**
Other Form of Proof		**Date Documentation Viewed**	**Person Viewing Documentation**

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section § 22.1-289.049 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction, or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means. **This institution is an equal opportunity provider.**

PART TIME CONTRACT

This agreement is made by and between Emmanuel's Children Learning Center LLC. and _____, Parent/Guardian of _____. The following has been agreed upon between the two parties beginning _____:

I have read and agree to full contents of the Parent's Handbook. I understand that disregarding these policies can result in termination from child care enrollment.

I understand that I must follow the termination policy as it is written in the Parent's Handbook.*

I agree to the weekly/daily rate of $_____, to be paid every _____in advance for my child, _____. Our arrival time will be _____, and pick up time will be no later than_____ on the following days:

_____.

Any added time before or after those times will be discussed beforehand, or will be subject to late pickup fees.

This agreement shall be in effect until which time parent/guardian or provider has given termination notice in accordance to the Parent Handbook policy, or negotiation of a new contract.

THIS AGREEMENT AND THE PARENT HANDBOOK WHOLLY STATE THE OBLIGATIONS OF THE PROVIDER; THERE ARE NO OTHER IMPLIED OBLIGATIONS. ANY AMENDMENTS TO THIS AGREEMENT MUST BR IN WRITING AND SIGNED BY BOTH PARTIES.

_____ _____

Director Date

BOTH PARENTS MUST SIGN OR PARENT/GAURDIAN WITH SOLE CUSTODY OF THE CHILD:

_____ _____

Parent/guardian Date

_____ _____

Parent/guardian Date

*This will include late penalties, as stated in the policy, from date due to date paid, plus legal fees if applicable.

Revised May 2024

FULL TIME CONTRACT

This agreement is made by and between Emmanuel's Children Learning Center LLC.and _____, Parent/Guardian of _____. The following has been agreed upon between the two parties beginning _____:

I have read and agree to full contents of the Parent's Handbook. I understand that disregarding these policies can result in termination from child care enrollment.

I understand that I must follow the termination policy as it is written in the Parent's Handbook.*

I agree to the weekly rate of $_____, to be paid the Friday before the week begins for my child, _____. Our arrival time will be _____, and pick up time will be no later than_____ From Monday through Friday. Any added time before or after those times will be discussed beforehand, or will be subject to late pickup fees or early arrival fees.

This agreement shall be in effect until which time parent/guardian or provider has given termination notice in accordance to the Parent Handbook policy, or negotiation of a new contract.

THIS AGREEMENT AND THE PARENT HANDBOOK WHOLLY STATE THE OBLIGATIONS OF THE PROVIDER; THERE ARE NO OTHER IMPLIED OBLIGATIONS. ANY AMENDMENTS TO THIS AGREEMENT MUST BR IN WRITING AND SIGNED BY BOTH PARTIES.

_____ _____

DIRECTOR Date

BOTH PARENTS MUST SIGN OR PARENT/GAURDIAN WITH SOLE CUSTODY OF THE CHILD:

_____ _____

Parent/guardian Date

_____ _____

Parent/guardian Date

*This will include late penalties, as stated in the policy, from date due to date paid, plus legal fees if applicable.

Revised May 2024

Emergency Contact Information

Child's Name:	
Birth date:	
Street address:	
City, State, Zip Code:	

Sibling(s) Name:	Birth date:	Living in Child's Home? (Y/N):

Mother's (guardian's) name:	
Home street address (if different):	
City, State, Zip Code:	
Home Phone:	

Father's (Guardian's) name:	
Home street address (if different):	
City, State, Zip Code:	
Home Phone:	

Please list two people who can be contacted in an emergency if the parent(s) or guardian(s) cannot be reached:

1st Alternate Contact:	
Relationship to child:	
Home street address:	
City, State, Zip Code:	
Home Phone:	
Is this person authorized to make medical decisions for your child if you cannot be reached? Yes_____ No _____	

2nd Alternate Contact:	
Relationship to child:	
Home street address:	
City, State, Zip Code:	
Home Phone:	

Emergency Contact Information

Is this person authorized to make medical decisions for your child if you cannot be reached? Yes_____ No _____

Child's Doctor (or name of clinic):	
Preferred Practitioner:	
Street Address:	
City, State, Zip Code:	
Telephone Number:	

Child's Dentist (or name of clinic):	
Preferred Practitioner:	
Street Address:	
City, State, Zip Code:	
Telephone Number:	

This is a legally binding form. By signing below, you state that all of the information contained on this form is correct to the best of your knowledge. Giving false information would be grounds for termination of childcare services, forfeiture of retainer, or both.

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date
Provider Signature	Date

Child Admission Record

Date of Enrollment: _____

Child's Name: _____

General Information:

Date of Birth: _____

Social Security Number: _____

Home Address: _____

Phone Number: _____

Father/Guardian Information:

Father or Guardian Name: _____

Father's Social Security Number: _____

Father's Contact Phone Numbers: _____

Address (if different from child): _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

E-mail Address: _____

Mother/Guardian Information:

Mother or Guardian Name: _____

Mother's Social Security Number: _____

Mother's Contact Phone Numbers: _____

Address (if different from child): _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

E-mail Address: _____

Emergency/Medical Information:

If neither parent or guardian can be reached in case of an emergency call: _____

_____

Child's Doctor (name, address, phone): _____

Child's Dentist (name, address, phone): _____

Child's Hospital of Choice: _____

Insurance Information: _____

What illnesses has your child had in the past month? _____

What treatment was given? _____

When was the last prescription medicine given to this child? _____

Has your child had any illness in the past 24 hours? _____

If so, describe illness and treatment: _____

Family/Home Information:

Other children in family (list relation): _____

_____

Other adults in family (list relation): _____

_____

Child's Normal Schedule:

Breakfast for the child usually consist of_____

Time the child usually eats breakfast_____

Time the child usually takes AM nap is_____

Time the child usually wakes up from AM nap is_____

Time the child usually eats lunch is_____

Time the child usually takes PM nap is_____

Time the child usually wakes up from PM nap is_____

Information About Child:

Please give information concerning your child, which will be helpful to the childcare provider.

Play Habits: _____

Eating Behavior: _____

Sleeping Pattern: _____

Fears: _____

Likes and Dislikes: _____

Other: _____

The child's temperament is usually _____

Does the child have a comfort item for resting? Yes No If yes what is it?_____

Your routine for putting the child to sleep is_____

He/She likes to sleep on their Stomach, Back or Side_____

Is your child toilet trained? _____

If not, are they trying to use the toilet? _____

What words does he/she use for the bathroom? _____

Does your child have any special needs or behaviors I need to be aware of? _____

_____

_____

Child Care Information:

Do you have a back-up provider? Yes No

If yes, Name, address, and phone number: _____

_____

Previous experience(s) in childcare (include dates): _____

_____

Are there any holidays you DO NOT want to participate in? _____

_____

Are there any foods you DO NOT want your child to eat? _____

_____

Any other information about your family or child that you wish us to know:

_____

_____

_____

_____

_____

Permission for Activities:

I/We hereby give ECLC permission to take my/our child _____ off the premises and on excursions that will take place during regular childcare hours. I understand that I will be notified of any such trips beforehand, that trips will be supervised and that all precautions will be taken for the safety and well being of all the children. I/We also understand that ECLC will not be liable for any accident or injury.

Consent is for normal activities unless indicated below ~ the following activities may occur during the course of the day at ECLC.

Please initial those activities your child **does not** have permission to participate in:

_____Go for walks

_____Ride a bike

_____Play in water

_____Go to a park

_____Ride in wagon/stroller

_____Go on field trip

Are there any other activities in which your child should not participate?

_____

_____

_____

Photo Permission:

I/We give permission for ECLC to use our child, _____, photograph on the website, fliers, brochures, or any other publication relative to ECLC. We realize that our child's first or last name will not be used in such publications.

Child Release Information:

No child may be released from the provider's home to any person other than his/her parents or other person currently designated in writing by such parent to receive the child. Those people authorized to pick up the child (including parents) need to present photo identification each day until easily recognized by the provider.

The following persons have my permission to pick up my child from the provider's home:

Name_____ Phone _____

Relationship to child _____

Name_____ Phone _____

Relationship to child _____

Name_____ Phone _____

Relationship to child _____

Relationship to child _____

Name_____ Phone _____

Relationship to child _____

I/We certify that all of the information given on this form is correct and accurate to our best knowledge. I/We promise that I/we will notify the provider, if any or all of the information changes.

_____ _____

Mother's Signature Date

_____ _____

Father's Signature Date

_____ _____

Provider's Signature Date

Photo Release Consent Form

I, the undersigned, give my permission to Emmanuel's Children Learning Center to use photographs, audio and video recordings and facsimile images of my child for news releases, educational materials and/or promotional documents. These materials might include printed or electronic publications, websites or other electronic communications. I authorize the use of these images without compensation. When images are published, ECLC will not use identifying information. ECLC will not use complete names, specific street or mailing addresses, e-mail address, or phone numbers of the child.

_____

Minor's Name

_____

Your Name (Parent/Guardian) please print

_____

Your Signature

_____

Date

ENROLLMENT CONTRACT

It is my/our desire to have my/our child/children enrolled in the daycare program at **Emmanuel's Children Learning Center LLC.**

I/we have received a copy of the **Emmanuel's Children Learning Center, LLC.** policy handbook. I/we have read, understand and agree to abide by the policies contained therein. I/we also understand that my/our child is being accepted on a two week trial basis. During this time, the staff will make observations and evaluations pertaining to the child's ability to adapt to the daycare surroundings. Unless otherwise notified, the child/children will be accepted and permanently enrolled. I/we further understand that if the policies outlined in this handbook were not adhered to, it would be sufficient cause for the removal of the child/children from the daycare program.

I/we also agree to give a minimum of two weeks written notice (ten full daycare days) of my/our intent to withdraw my/our child/children from the daycare program. If two weeks notice is not given, I/we agree to make full tuition payment for the final two weeks. Unpaid vacation/sick days cannot be applied to the final two-week period.

Please **initial** next to each item. We want to be sure you **understand and agree** to these policies.

_____ I/we understand that I/we must provide a completed medical form to the daycare.

_____ I/we understand the daycare fees are _____ for school weeks and _____ for vacation weeks.

_____ I/we understand there will be extra charges during school weeks if there is a snow day or late start or early dismissal.

_____ I/we understand daycare payment is due Monday. Late fees are $5.00 per day.

_____ I/we have contracted for the hours of _____ to _____ .

_____ I/we understand the late pickup/early drop off fee is $2.00 per minute.

_____ I/we understand the pick up policy for other than parental pick up.

_____ I/we understand the illness policy. _____ I/we understand the meal policy.

_____ I/we are contracting for (year round, school year only, summer only) arrangements.

_____ I/we understand the behavior policy and I/we have read and shared the daycare rules with my/our child/children.

_____ I/we understand the returned check policy.

_____ I/we understand that I/we will make all payments during the first three months of child care as none of the 10 non payment days may be used during this time.

_____ I/we understand that if I/we are contracting for child care for the school calendar usage - Sept. thru June, these 10 days without payment are not available to me/us

_____ I/we agree to pay the last two weeks tuition during the first two weeks of enrollment.

_____ I/we have contacted references.

_____ _____

Emmanuel's Children **Parent** **Date**

BITING IN DAYCARES

DEAR: _____
YOUR CHILD: _____, was bitten by another child today.

The location of the bite on your child's body is as noted: _____
_____

First aid was administered? ____yes _____no
What kind of first aid? _____
What action was taken to the offending child? _____
_____
What action will be taken to further prevent this from happening again? _____
_____

Severity of bite: _____mild _____normal _____severe _____requires a visit to doctor.

Please call me if you wish to further discuss this report or if you have any comments, or questions.

WHY DO KIDS BITE?

- Young children have not fully mastered the skill of communication. They are unable to tell you how they feel and get really frustrated. They lack the verbal skills they need to express themselves.
- Biting is a very powerful release of frustration, leadership, or anger.
- Most children stop biting around the age of 3, when they are better able to acquire their verbal skills.
- Biting often results from frustration. Toddler hood is frustrating as toddlers learn new physical and social skills.
- They could be teething.
- A child may be hungry or tired. They lack good judgment when they are either of these.
- They may have seen another child do it and want to try it too.
- They know it gets a great reaction, and use it as a way to express leadership.
- Maybe an adult has bit or nibbled them during play. A child does not know his own strength and thinks that he/she is playing when they bite. When in fact, they are actually harming them.
- They have never been corrected for doing this in the past.

How can I prevent biting from happening in the first place?

- Plan activities that allow children to release frustration. Show them how to stomp their feet, push, or kick a pillow. Scream, freak out, breathe or take a time out.
- Have age appropriate toys available that stimulate interest and decrease frustration and/or boredom. Have enough toys to share so that each child does not feel the need to hog it.
- Provide biting substitutes such as teethers, wet washcloths, etc.
- Supervise at all times.

What should I do after a child has been bitten?

- The biting child is calmly removed and given "quiet time" alone. Statements such as "You do not bite. It hurts." Or "Biting is not allowed. It hurts people." Are used.
- The bitten child is consoled and the bite is quickly cleaned. Ice is placed on the bite to decrease the likelihood of swelling or bruising.
- Call parents to notify them that their child was bitten so that they are not shocked when they arrive, and that they will be given a choice to come examine the child.
- If the skin has been broken report the incident to your Local Health Department. A hepatitis shot or other related injections may be needed.
- Have the child examined by a doctor if it is severe.
- The child who has bitten is "shadowed" to help understand what may be causing the child to bite so that further incidents can be prevented.

Things you should not do:

- Bite the child back.
- Encourage the other child to bite the child back.
- Call the child names such as "bad", "naughty
- Spank or threaten the child.

Illness Policy

PARENTS AGREE TO KEEP THEIR CHILD/CHILDREN AT HOME OR SEEK ALTERNATE CARE ARRANGEMENTS FOR THE FOLLOWING CONDITIONS:

- Pain - any complaints of unexplained or undiagnosed pain
- Fever (100°F/38.3°C or higher)
- Sore throat or trouble swallowing
- Headache or stiff neck
- Unexplained diarrhea or loose stool combined with nausea, vomiting or abdominal cramps. The child will be kept at home until all symptoms have stopped.
- Nausea or vomiting
- Sever itching of body and scalp
- Known or suspected communicable diseases.

IT IS REQUIRED TO KEEP (OR TAKE) A CHILD HOME WHEN THE CHILD:

- Is suffering from one or more of the above symptoms
- Is not well enough to take part in the activities at the daycare

ULTIMATELY THE CARE OF THE CHILD IS THE PARENT'S RESPONSIBILITY

Parents will inform the daycare within 24 hours of a diagnosis of a serious illness or contagious disease of a communicable nature in the family. This is to protect my family and the other families who attend the daycare. Failure to do so is grounds for immediate termination of care.

Parents agree that a child will be symptom free, without the aid of symptom reducing medications such as Tylenol, for a full 24 hours prior to returning to daycare. We reserve the right to ask for a note from your family doctor, depending on the illness/disease.

<u>MEDICATIONS:</u>

Prescription medications will only be given to a child in care with the following conditions:

- Parent gives written permission to the caregiver, with full instructions as to dosage, and times to administer medication. (forms are available from the daycare for this purpose)
- All prescribed medications must have the child's name on the prescription bottle.
- Non-prescription medications will be administered as per recommended dosages on medicine bottle.

CARE OF A SICK CHILD AND NOTIFICATION OF PARENTS

When a child becomes ill, I will make the child comfortable in a quiet place where he/she can rest and will be closely supervised.

Parents will be notified immediately and agree to begin to making alternate work arrangements or arrangements for alternate care. If your child is seriously ill, you or an alternate must come for the child IMMEDIATELY. If I cannot reach a parent, I will call an emergency contact listed on the registration form or the child's doctor may be contacted depending on the seriousness of the illness.

ILLNESSES REQUIRING EXCLUSION FROM DAY CARE

- Fever, defined by the child's age as follows until medical evaluation indicates inclusion:
  - Infants 4 months old and younger – rectal temperature greater than 101° F or auxiliary (armpit) temperature greater than 100° F even if there is no change in their behavior.
  - Infants and children older than 4 months (accompanied by behavior changes or other signs or symptoms of illness) – rectal temperature of 102° F or greater, oral temperature of 101° F or greater, or auxiliary (armpit) temperature of 100° F or greater.
- Signs possible severe illness, including unusual lethargy, irritability, persistent crying, difficult breathing.
- Uncontrolled diarrhea, defined as an increased number of stools compared with the child's normal pattern, with increased stool water and/or decreased form that is not contained by the diaper or toilet use.
- Vomiting two or more times in the previous 24 hours unless the vomiting is determined to be due to a non-communicable condition and the child is not in danger of dehydration.
- Mouth sores with drooling unless the child's physician or local health department authority states the child is non-infectious.
- Rash with fever or behavior change until a physician has determined the illness not to be a communicable disease.
- Purulent conjunctivitis, defined as pink or red conjunctiva with white or yellow eye discharge, often with matted eyelids after sleep, and including a child with eye pain or redness of the eyelids or skin surrounding the eye.
- Infestation (e.g., scabies, head lice), until 24 hours after treatment was begun.
- Tuberculosis, until the child's physician or local health department authority states the child is non-infectious.
- Impetigo, until 24 hours after treatment was begun.
- Streptococcal pharyngitis, until 24 hours after treatment has been initiated, and until the child has been afebrile for 24 hours.
- Ringworm infection (tinea capitis, tinea corporis, tinea crusis, and tinea pedis) until 24 hours after treatment was begun.
- Shingles, only if the sores cannot be covered by clothing or a dressing, until the sores have crusted.
- Pertussis, which is laboratory confirmed, or suspected based on symptoms of the illness, or suspected because of cough onset with 14 days after having face-to-face contact with a laboratory confirmed case or pertussis in a household or classroom, until 5 days of appropriate chemoprophylaxis (currently, erythromycin) has been completed.
- Mumps, until 9 days after onset of parotid gland swelling.
- Hepatitis A virus infection, until 1 week after onset or illness or until after immune serum globulin has been given to appropriate children and staff in the program, as directed by the responsible health department.
- Measles until 6 days after the rash appears.
- Rubella until 6 days after the rash appears.

If you have any questions or concerns, please contact us PRIOR to bringing your child to day care.

Emmanuel's Children Learning Center

Child's Emergency Medical Authorization

Name of child: _____ Date of birth: _____

Name of parent(s) or guardian: _____

Home address: _____ Phone: _____

Parent/Guardian #1 place of employment: _____

Parent/Guardian work phone number: _____ Cell phone: _____

Parent/Guardian #2 place of employment: _____

Parent/Guardian work phone number: _____ Cell phone: _____

The parent(s)/guardian(s) authorizes Emmanuel's Children Learning Center to obtain immediate medical care and consents to the hospitalization of, the performance of diagnostic test upon, the use of surgery on, and/or the administration of drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be related. Otherwise, he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses: _____
2. Medical treatment costs are covered by:
    a. Blue Cross/Blue Shield-Policy Number: _____
    b. Medical Coverage Number: _____
    c. Other Medical Insurance:

Name of insurance company: _____

Policy Number: _____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Name of Parent or Legal Guardian 2: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Emergency Contact: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): _____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) ____ FAMIS ____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. ***This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.***

Signature of Parent or Legal Guardian: _____ Date: ____/____/_____

Signature of person completing this form: _____ Date: ____/____/_____

Signature of Interpreter: _____ Date: ____/____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official. See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

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

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):** ___/___/___

Student's Name:_____ Date of Birth: |__|__|__|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |__|__|__|.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|__|__|__|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|__|__|__|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ___/___/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ___/___/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP: _____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ **No risk for TB infection identified** ☐ **No symptoms compatible with active TB disease**
☐ **Risk for TB infection or symptoms identified**

Test for TB infection: TST IGRA Date:_____ **TST Reading** _____**mm TST/IGRA Result:** ☐ **Positive** ☐ **Negative**

CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ ☐ **Normal** ☐ **Abnormal**

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead: _____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

Stereopsis	☐ Pass	☐ Fail		☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test – needs rescreen**

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ **Well child; no conditions identified of concern to school program activities**

☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____

Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___ **Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ **Date:** ___/___/_____

Practice/Clinic Name: _____ **Address:** _____

Phone: _____-_____-_____ **Fax:** _____-_____-_____ **Email:** _____