Child Care Subsidy Parents Agreement Form

Dear_________________________

Our full-time/part-time weekly rate for an/a _________ is $_________. A portion of the payment will be paid through another agency such as (Department of Social Services, Samaritan House, ForKids, etc.. The remaining balance is your responsibility.

Additionally, you may be responsible for the childcare payment if:

** You fail to check in or out (using the VA-ECC card) for days while the child is in attendance and receiving care;

** Your swipe card gets denied and you did not get it corrected with in 9 days by notifying your childcare worker;

** The provider loses an absent day payment or holiday payment because you did not repot the holiday or absent day with the swipe card;

** If you fail to comply with your agency's rules and regulations.

Client Signature:_____________________

Date:________________________________

**** Client's portion of the payment must be paid in advance and is due on the 1st of each month by 5:00pm, unless other arrangements have been agreed upon. Due dates apply regardless of attendance. If the 1st occurs on a holiday, payment must be paid the day prior. If the 1st occurs during the weekend, payment must be made on the Friday before. Payment may be made by check, money order, or credit card. ****

Enrollment Registration Information
Enrollment Agreement

Name of Child (Last, First, Middle Initial): ___________________________________
Date of Birth: ____________________
Parents/Guardian Name: ____

Please Initial each section listed below, then sign and date the last page

_______ **REGISTRATION FEE:** I understand that an annual, non-refundable, Registration Fee of $______shall be paid in advance to enroll my child. I understand that I may guarantee my child's enrollment by paying this fee no later than ___________ **of each year.** In instances of agency reimbursement, the Registration Fee is to be paid according to the applicable contract.

_______ **TUITION: $____** per week, is the current tuition rate for the program I have chosen. I understand that rates are subject to change yearly with reasonable notice. The school follow state specific required time frames on tuition and modifications notices.

I have enrolled my child in the following service(s):
Full-Time Care or **Part-Time Care**
Days: (check all that apply) **M ON TUE WED THUR FRI**
Times: _______ **am/pm** to _______**am/pm**

_______ **PAYMENT OF TUITION:** I understand that tuition is due and payable, on the first day of attendance each week.

_______ **LATE OR UNPAID TUITION and CO-PAYS:** If payment in full is not received when due, I agree to pay a late payment fee of **$25** per week(s) that tuition is not received. All late fees are subject to change with reasonable notice. I understand that if my account is delinquent for more than one week, I may be asked to withdraw my child until my account is made current. The Center cannot guarantee a child's spot will be held when a child is withdrawn due to non-payment of tuition. Any unpaid tuition fees may be sent to a third-party collection agency.

_______ **AGENCY REIMBURSEMENT:** I understand that I am solely responsible for any tuition payment and late fees in excess of any agency or third-party reimbursement in accordance with the applicable contract. I also understand that I am solely responsible for promptly communicating any changes in my status that would affect my agency reimbursement, and that I am solely responsible for payment of any tuition in excess of any agency or third-party reimbursement resulting from my failure to promptly communicate status changes. If I fail to properly enter or swipe attendance for any day my child is in attendance, I understand that I am solely responsible for the payment of tuition.

Enrollment Registration Information
Enrollment Agreement

_______ **CHARGES AND PROCEDURE FOR LATE PICK-UP:** My child is enrolled from _______ **am/pm** to _______**am/pm** Monday through Friday all year, except for holidays. I understand that if I fail to pick up my child by the scheduled end time, I will be charged a late fee of **$1** per minute, per child, until the child is picked up.

_______ **DISCOUNTS:** I understand that if I have more than one child enrolled and attending from my immediate family a **$10 discount** from the monthly tuition fee is offered to me and is applied to the other child(ren)'s tuition rate(s). These discounts are only available to those accounts when full tuition is paid in advance. Discounts are not applicable on any fees or services, Agency Co-Pays, or special program promotions and cannot be combined with other discount or promotion.

_______ **ACTIVE MILITARY: YES / NO**. I understand I will receive a discount of **$25** off of the monthly rate if I or my spouse is an active military member(s). These discounts are only available to those accounts when full tuition is paid in advance. Discounts are not applicable on any fees or services, Agency Co-Pays, or special program promotions and cannot be combined with other discount or promotion.

_______ **RETURNED CHECK:** I understand that a processing fee will be charged to my account for all checks which are returned for any reason, and this fee is in addition to any charge that my bank or financial institution may charge me. I understand that any non-sufficient funds checks will be automatically resubmitted electronically up to three times. I further understand that once a check has been processed electronically, the check is no longer negotiable and will not b returned. F more that two checks are returned within a six-month period, I will be required to pay by an alternate method of payment for the next six-month period. If my Daycare Center uses Telecheck, I am authorizing the payee or its agent, upon receipt of my check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to my account, in accordance with the same terms and conditions as my check. In the event that my check is returned for a non-payment, Telecheck will make up to two additional electronic collection attempts and, if needed, by paper draft thereafter. The maximum fee allowed by state law will be charged for all returned checks. I am responsible for the principal amount plus all returned check fees.

_______ **DAILY SIGN-IN AND SIGN-OUT:** I agree to sign my child in and out every day using the Center's attendance procedure. I understand that my child is not permitted to sign him/herself out. I understand that I am required to enter the Center to drop off and pick up my child and that I must escort my child to and from the designated classroom and staff member each day. In sates where a manual signature is required due to stat childcare licensing regulation, I agree to complete the required computer and manual sign-in and sign-out procedures.

Enrollment Registration Information
Enrollment Agreement

_______ **ILLNESS:** I understand that I will be notified should my child become ill during the day, and that I will pick up my child promptly, or make arrangement for and authorized emergency contact person to pick up upon such notification and no later than one (2) hour after being contacted. If my child is exposed to or contracts a contagious disease, I agree to notify the Center and I understand that my child will be readmitted only with a physician/health care professional's note indicating that my child is no longer contagious. Please refer to criteria in the Parent/Student Handbook.

_______ **MODEL RELEASE:** The Company, its agents, affiliates, and licensees, **MAY** or **MAY NOT** use photographs, reproductions, images, or sound recordings of my child for advertising, publicity or any other lawful purpose.

_______ **PHOTOGRAPHS, VIDEOS AND AUDIO TAPES**. I understand and agree that in consideration for being allowed to photograph, videotape or audio record my child on company property. I shall only use such recording for awful and private home us, and will not publish, publicly display or sell such recordings. I also understand that I must have written permission before capturing any images of that other children in the Daycare Center or staff.

_______ **INTERVIEWING CHILDREN AND INSPECTING RECORDS**. I understand that the stat child care regulatory enforcement and administration agency and the local department of social services or child protective services has the authority to interview children or staff, to inspect and audit child or facility records, to interview children privately, to observe the physical condition of the children in the Daycare Center, to make provisions for the independent medical examination by the licensed physician of any child, and to contact and instruct any other appropriate authority to do the same, without prior notice or consent by myself of by the Daycare Center.

_______ **WITHDRAWAL FROM PROGRAM**. I understand that I must provide a thirty (30) day written notice of withdrawal from the program. Within this notification period, I agree to pay all tuition and fees for thirty (30) days whether or not my child attends. I understand that when my child is withdrawn, s/he will only be eligible for re-admission re-enrollment, I will be required to complete an entire new Enrollment Agreement at the current rate and pay new non-refundable Registration Fee at the current rate. If there is an outstanding balance (including tuition or fees) when my child was withdrawn, I will be required to bring my account current prior to completing a re-enrollment application. I understand all fees (Tuition, Registration) are non-refundable.

Name of Child (Last, First, Middle Initial): ______________________________

Date : ____________________

Parents/Guardian Initial: ______________________________

Enrollment Registration Information
Enrollment Agreement

_______ **HOLIDAYS:** I understand that the Center is closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day. I agree that I will not receive a refund, credit or any other allowance for holidays. If a holiday falls on a weekend, it will be observed on either the preceding Friday or the following Monday.

_______ **ABSENCES/VOCATIONS:** I agree to inform the Center immediately if my child will be absent on any day. I understand that no allowances, credits, refunds, or makeup days shall be made for occasional absences (i.e. sickness). I agree to pay weekly tuition to guarantee my child's space when my child is not in attendance for an entire week (Monday through Friday). My regularly contracted tuition is due for all weeks when my child attends ay part of the week. There is no credit given for single days. I also understand that if I withdraw my child during a vacation, I will be required to pay a new non – refundable registration fee upon return.

_______ **WALKING TRIPS**: I give permission for my child to leave the center for outdoor exercise and educational purposes, what the understanding that my child will be accompanied by center staff and under proper staff supervision at all times. (If required by individual state childcare licensing regulation, I will be given a specific permission slip for each walking trip.)

_______ **TRANSPORTATION:** I give permission for my child to participate in and to be transported while under proper staff supervision at all times for field trips, to and from Daycare Center, educational excursions and other center sponsored activities. I will be given a specific permission slip for each off-site field trip. Off-site field trips and all transportation of children will meet state childcare licensing regulations and center policies including minimum age requirements.

_______ **EMERGENCY CLOSING AND INCLEMENT WEATHER INFORMTATION:** I understand that it is the company's intention to be open and provide child care services every weekday of the year, excluding holidays, but that inclement weather, natural/national disaster or major building issue may disrupt service from time to time. I will contact the Cerner to ensure that it is open during inclement weather/natural disaster. In the event that the center is closed for emergency or inclement weather, I will check the center's voicemail, as will as the website for updates.

_______ **MEDICATION:** Individual state childcare licensing regulations regarding medication must be followed. Any mandatory state form regarding administration of prescription or non-prescription medication must also be completed and signed by a parent/guardian. I will provide written authorization for the Center staff to administer medication in accordance what written instruction from the child's health care professional or me, as permitted by state childcare licensing regulation. I will complete and sign authorization forms. I will provide the medication in it's original container (with the pharmacist's label for prescriptions). Medications will not be provided by the center.

Enrollment Registration Information
Enrollment Agreement

_______ **MEDICAL POICIES:** I understand that I will be asked to provide the center with updated immunization information for my child. If I wish to request a religious or medical exception to the Center's practice of securing immunization information , I understand my request must meet state childcare licensing regulations. I may also be asked to provide additional medical information as required by stat childcare licensing regulations. I understand that my failure to provide this information may result in a suspension of services. I agree to promptly provide information to the center regarding any conditions, illnesses, and allergies that my require specific care or attention and agree to provide additional documentation as needed. In case of a medical or other emergency while my child is under the center's supervision. I understand that the center staff will attempt to contact me immediately: however, in the event that I cannot me reached, or when a delay my further jeopardize my child's health, I hereby authorize center staff to ace on my behalf and to take the emergency measures including those listed below if deemed necessary by center staff or by medical authorities for the care and protection of my child. I authorize the Center staff members to:

- Consult the designated physician or dentist if I cannot be reached.
- Administer first aid and/or cardiopulmonary resuscitation.
- Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility, if deemed necessary by paramedics, police, or other emergency personnel.
- Obtain any emergency medical or dental treatment deemed necessary by medical authorities.
- Transport my child to a local emergency shelter in the event of an emergency evacuation of the center.

If I wish to request a religious or personal exemption to the Center's practice of securing necessary emergency medical treatment, I understand stat childcare licensing authorities must be consulted to determine if such and exemption may be granted. I will provide written authorization for the Center staff members to administer medication in accordance with written instructions from the child's heal care professional or me, as permitted by state child licensing regulations. I will complete and sign authorization forms. I will provide the medication in its original container (where the pharmacist's label for prescriptions). Medications will not be provided by the center.

_______ **ALL POLICIES & STATE REGULATIONS:** I understand that the above policies are not an all-inclusive list of policies, and that my child, my family members, authorized agents, and I are bound by state child care regulations, the Parent/Student Handbook, and all other company policies, which may be modified at any time, without notice. I also understand that the childcare regulations of the state in which my child attends may prevail over these policies when the state regulation is stricter. I further understand that my continued enrollment constitutes my acknowledgement of, and agreement to abide by, all Policies and state regulations.

Enrollment Registration Information
Enrollment Agreement

_______ **PARENT/STUDENT HANDBOOK:** I have received a copy of the Parent/Student Handbook. I have read and understand tits contents and pokies and agree to be bound by same.

_______ **NO MODIFICATIONS:** No terms of this Agreement may be altered, revised, modified, or deleted by any person except in cases of policy change or rate change to which both the Director and I much initial. Any alterations, revisions, medications, or deletions of any term of the Agreement are null and void.

We do not discriminate based on disability in the admission/enrollment or access to our programs or services. Information concerning the provisions of the Americans with Disabilities Act (ADA), including the rights provided thereunder, is available from the Director.
There policies have been reviewed with me by Center management. I understand an will comply with the policies included in the Enrollment Agreement and Parent/Student Handbook.

Parents/Guardian Signature: ______________________________ **Date:**______________________

Parents/Guardian Name: ____

Directors Signature: ______________________________________ **Date:**______________________

Name of Child (Last, First, Middle Initial): ____

Date : _________________________

Parents/Guardian Initial: ______

DIVISION OF LICENSING PROGRAMS
DEPARTMENT OF SOCIAL SERVICES
CHILD REGISTRATION FORM (Model)

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	

PARENT(S)/GUARDIAN(S)

Father	Place Employed	Business Phone
Home Address		Home Phone
Mother	Place Employed	Business Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Business Address		Business 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 1.	Address 1.	Phone 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 must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day care activities.

AGREEMENTS

1. The child day center 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 the child day center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center 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.

SIGNATURES

______________________________ ______________

Parent(s) or Guardian(s) ***Date***

______________________________ ______________

Administrator of Center ***Date***

Date Child Entered Care: ________________ Date Left Care: ________________

** 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):

____

Date

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 63.2-1809 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.

Pre-Admission
Background Information Form

The center staff needs your help to understand and plan for your child. Please fill out the following form and return it to the center before enrollment.

Date ____________________

Child's Name ______________________________ Sex: M________ F________
(Last) (First) (Middle)

Child's Preferred Name ______________________________(First, Middle or Nickname)

Complete Address ______________________________

Phone Number ____________________ Birth Date ________________Age____________
m/d/y

Admission Date ______________________________ Termination Date ________________

Grade Level ____________________ School__________________________

Father's Name ______________________________
(Last) (First) (Middle)

Occupation ______________________________ Company ________________

Business Address ______________________________

Business Phone # ______________________________ Cell # ____________________

Mother's Name ______________________________
(Last) (First) (Middle)

Occupation ______________________________ Company ________________

Business Address ______________________________

Business Phone # ______________________________ Cell # ____________________

Is Father living? ______ Is Mother living? ________ Separated? ______Divorced? _______

Please list persons authorized to pick up your child:

____

____

____

____

Is there anyone whom you **do not** wish to pick up your child? ____________________

If so, please give name and relationship to child.

Name ______________________________ Relationship to child ________

Other members of the family (brothers, sisters, grandparents, etc.) living at home:

Name	Age	Relationship	Indicate Name Used by Child
____________	______	____________	____________
____________	______	____________	____________
____________	______	____________	____________
____________	______	____________	____________
____________	______	____________	____________
____________	______	____________	____________

Other members of the family (grandparents, aunts, uncles, etc.) living in the community:

Name	Age	Relationship	Indicate Name Used by Child
____________	______	____________	____________
____________	______	____________	____________
____________	______	____________	____________

Has your child had any previous school experience? ____________________

If so, please give name and type of school

______________________________ Length of attendance ________

Does your child take a nap? __________ Morning ___________ Afternoon __________

How many hours does your child sleep at night? (Approximately) ______________

Is your child toilet trained? ______ Does your child use any special word for toileting? ______

If so, please state ______________________________

Describe your child's appetite:
always hungry_______ never hungry _______ snacks _______ snacks all day _______
eats at mealtime _______ has to be coaxed to eat _______
Are there any foods your child may not or cannot eat? (due to allergies, religious customs, etc.) ______________

If so, please list: ______________________________

Are there any foods your child dislikes? __________ If so, please list:

____

____

____

Child's Special Interests: singing ________ painting ___________ stories ___________

trucks ___________ pets ___________ music ___________

outside play ___________ coloring ___________ Other __________________________

Is your child generally:

cooperative? __________shy? ________ competitive? ________ happy? ___________

aggressive? ____________ sensitive? _______________ submissive? ____________

angry? ___________

Your child usually does what is asked of him/her? ______________

Your child seldom does what is asked of him/her? ______________ whines? ________

List other behaviors characteristic of your child.

____

____

____

The Midtown Children's Center

Health History

(to be provided by parents)

Name ____

Birth Date ______________________________ Sex __________

m/d/y

Child's Social Security Number ______________________________

Medical History

Diseases:

Asthma	________	Pneumonia	________
Chicken Pox	________	Whooping Cough	________
Heart Disorder	________	Diphtheria	________
Measles	________	Mumps	________
Rubella	________	Other	________

Congenital Malformations ______________________________

Allergies (drug, food, etc.) ______________________________

Drug Sensitivities ______________________________

Seizures ______________________________

Comments ______________________________

____

____

____

____

Parent's Signature ______________________ Date ____________

Address ______________________ Phone # ____________

Child's Emergency Medical Authorization

Name of Child ______________________________ Birth date ____________

Name of Parent(s) or Guardian ______________________________

Home Address ______________________________ Telephone #____________

Place of Mother's Employment ______________________________ Telephone #____________

Address ______________________________ Cell #____________

Place of Father's Employment ______________________________ Telephone # ____________

Address ______________________________ Cell #____________

The Parent(s)/guardian authorizes ______________________________

(Name of Day Care Center Operator)

to obtain immediate medical care and consents to the hospitalization of, the performance of necessary 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 reached. 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. Private Insurance (name & policy no.) ____________
   b. Medicaid Coverage No. ____________
   c. Other medical insurance:
      Name of Insurance Company ____________
      Policy No. ____________
   d. No insurance ____________

Child's physician or clinic attended ______________________________

Attached is a copy of the agreement with:

Child's parent(s) or guardian and the day care center operator. Yes ________ No ________

____

Signature (Parent(s)/Guardian) Date

This form is to be kept by the day care operator and is to be taken to the doctor or treatment facility in case of emergency.

Childcare Supplies Agreement

(please initial and fill in the blanks)

1. _______ I decline the provider's offer to supply ______________________ infant formula form my child. I will supply ______________________ formula only. I accept the provider's offer to supply other meal components.

2. _______ I accept the provider's offer to supply ______________________ formula and other meal components for my child.

3. _______ I decline the provider's offer to supply any infant formula or other meal components for my child. I will supply all food for my child.

4. _______ I will supply breast milk for my child. I accept the provider's offer to supply other meal components.

5. **ALL PROVIDERS MUST CHECK ONE**

________ **Parent** prepares the formula for the infant
________ **Provider** prepares the formula for the infant

Parents/Guardian Signature: ___________________________ **Date:**____________________

Parents/Guardian Name: ____

Provider's Signature: __________________________________ **Date:**____________________

Field Trip and Activities Permission

Childs Name: ______________________________ **Teacher:**______________________

I grant permission form my child to participate in the neighborhood walks or field trips in an authorized vehicle. I understand that I will be informed of a planned field trips and that I may withdraw my permission for a planned trip I so desire.

I grant my permission for my child to be included in school pictures and give permission for those pictures to be used by the Center.

I grant my permission for my child to participate in the activities and in the use of the equipment at the Center.

Parents/Guardian Signature: ______________________________ **Date:**______________________

Parents/Guardian Name: ____

Directors Signature: ______________________________________ **Date:**______________________

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 Mother or Legal Guardian: ______________________ Phone: ____-____-______ Work or Cell: ____-____-_____

Name of Father or Legal Guardian: ______________________ 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 or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, 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: _____/_____/______

DO NOT USE THIS FORM. OBTAIN ORIGINAL FORM FROM THE VIRGINIA DEPARTMENT OF HEALTH.

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician, 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 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 <2 years 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* (Minimum requirements are listed in Section III).

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

DO NOT USE THIS FORM. OBTAIN ORIGINAL FORM FROM THE VIRGINIA DEPARTMENT OF HEALTH.

Student's Name:____Date of Birth: |____|____|____|

Section II
Conditional Enrollment and Exemptions

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ❑ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

DO NOT USE THIS FORM. OBTAIN ORIGINAL FORM FROM THE VIRGINIA DEPARTMENT OF HEALTH.

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

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: ______________mm

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	☐	☐	☐

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 ☐ epi pen ☐ 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):

Name : ______________________ **Signature:** ______________________ Date: ___/___/___

Practice/Clinic Name: ______________________ **Address:** ______________________

Phone: ____-____-________ **Fax:** ____-____-________ **Email:** ______________________

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