



Distribution
• Child's File

Enrollment Application

Entrance Date ___/___/___

Withdrawal Date ___/___/___

Child	
Child's Full Name _____	Age ___ Gender _____ Date of Birth ___/___/___
Child's Home Address _____	Home Phone _____

Parent/Guardian(s)	
Parent/Guardian Name _____	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Home Address _____	Home Phone _____
Email _____	Cell Phone _____
Place of Employment _____	Business Phone _____
Employment Address _____	
Parent/Guardian Name _____	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Home Address _____	Home Phone _____
Email _____	Cell Phone _____
Place of Employment _____	Business Phone _____
Employment Address _____	

Marital Status: Married Separated Divorced Widowed Other _____

Child's Legal Guardian(s): Both parents/guardians Mother Father Other _____

Child's Living Arrangements: Both parents/guardians Mother Father Other _____

Emergency Contacts			
The child may be released to the person(s) signing this agreement or to the following with photo ID:			
Name	Address	Telephone	Relationship
_____	_____	_____	_____
Emergency contact(s) when parents cannot be reached:			
Name	Address	Telephone	Relationship
_____	_____	_____	_____
Doctor to be contacted when parents cannot be reached:			
Name	Address	Telephone	
_____	_____	_____	

Parent/Guardian Signature

___/___/___
Date

Parent/Guardian Signature

___/___/___
Date



- Distribution**
- Child's File
 - Transportation Log
 - Field Trip Log (School-Age Only)

Health and Emergency Permission

This form must be completed for all enrolled children annually and as changes occur

Child			
Child's Full Name _____ Age _____ Gender _____ Date of Birth ____/____/____			
Child's Home Address _____		Home Phone _____	
Parent/Guardian(s)			
Parent/Guardian Name _____		Phone 1: _____	Phone 2: _____
Parent/Guardian Name _____		Phone 1: _____	Phone 2: _____
Medical Information			
Doctor to be contacted when parents cannot be reached:			
Name _____	Full Address _____	Telephone _____	
Dentist:			
Name _____	Full Address _____	Telephone _____	
Health Insurance Provider:			
Name _____	Full Address _____	Telephone _____	
Does your child have special needs affecting participation in school activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify: _____			
Does your child have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your child on prescribed medication for Illness/Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify: _____			
Actions Taken: _____			
Weight of Child: _____			
Emergency Contacts			
The child may be released to the person(s) signing this agreement or to the following with photo ID:			
Name _____	Address _____	Telephone _____	Relationship _____
Emergency contact(s) when parents cannot be reached:			
Name _____	Address _____	Telephone _____	Relationship _____

Parent/Guardian Signature

_____/_____/_____
Date

Owner/Director Signature

_____/_____/_____
Date

Parental/Guardian Agreement with Kids 'R' Kids # _____

1. Kids 'R' Kids # _____ agree to provide child care for _____ on M-Tu-W-Th-F from _____ am to _____ pm. Child's Full Name
2. I agree to pay the tuition fee of \$ _____ as designated by the school as well as a registration fee of \$ _____ that will be due annually. Payment will be due on _____.
3. My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____
_____.
- I agree to provide the school with all necessary information pertaining to the administering of medication (date, prescription #, Allergy Action Plan, doctor's notes, direction, medication in original pharmaceutical container, etc.).
4. I agree to follow all requirements of the school's medical policy.
5. My child has the following special needs that may affect participation in school activities: _____
_____.
6. The following special accommodation(s) may be required to most effectively meet my child's needs while at this school: _____.
7. I understand my child will be provided with all snacks and lunch served daily during his/her hours of attendance.
8. I understand I am responsible for any special diet required by my child and will provide a doctor's note indicating so. If my child's diet consists of breast milk or formula taken from a bottle, I understand I will provide Kids 'R' Kids with the appropriate number of bottles containing formula/ breast milk necessary for my child each day. Each bottle will be clearly labeled with my child's full name and current date.
9. If my child wears diapers, I understand I will provide whatever disposable diapers are necessary for my child. I understand that only disposable diapers are permitted in the school and that they will be changed every two hours, or as needed.
10. If child is off school age, what school does he/she attend: _____.
11. Transportation is provided to and from school and on planned field trips with parental/guardian permission. A separate form and signature are required for this service. A School-Age Transportation Agreement form must be signed each school year. A field trip agreement form must be signed before each field trip.
12. I give consent for my child to participate in the following water activities: water table play, sprinklers, slip and slide.
13. Should my child become ill during the time he or she is in the care of Kids 'R' Kids or suffers an accident of any nature, the school will contact me immediately and is authorized to secure such medical attention and care for my child as necessary. (The parent/guardian will assume responsibility for payment).
14. I understand that if my child is ill, including, but not limited to, a severe cough or sore throat, undetermined rash or spots, temperature over _____ degrees, severe headaches, upset stomach or diarrhea, he or she cannot be accepted into the school until well (24 hours well without symptoms or medication). In the event my child has a notifiable disease, a release form from a medical source may be required before my child can re-enter the school. Kids 'R' Kids will notify parents if a notifiable disease has been introduced into the school and guidelines will be followed per the CDC Chart/Health Dept.
15. I understand that Kids 'R' Kids # _____ a Kids 'R' Kids franchise, is independently owned and operated and that neither Kids 'R' Kids International, Inc. nor any other Kids 'R' Kids is responsible for the actions or obligations of this school.
16. I understand that it is my responsibility to escort my child into and out of the school. And to sign my child in and out of the school. I understand that a staff member will escort my child into the school when being transported from school by county or Kids 'R' Kids transportation.
17. If I have not picked up my child 30 minutes after closing, and all attempts to contact my emergency contacts and me fail, Kids 'R' Kids will call the proper authorities.
18. I understand that it is my responsibility to keep the school advised of any changes to the information provided in this application.

I agree to abide by the policies and procedures of Kids 'R' Kids as outlined in this agreement and the Parent Handbook. I have read and understand the above statements.

Parent/Guardian Signature

____/____/____
Date

Owner/Director Signature

____/____/____
Date



Distribution • Child's File

Photo and SocialMedia Release

For and in consideration of the opportunity to have my minor child's name, voice, picture, portrait, artwork and/or likeness published and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the undersigned, on behalf of myself and my minor child, hereby agree as follows:

1. I hereby grant Kids 'R' Kids International, Inc., Kids 'R' Kids # _____, and its affiliates, franchisees, nominees, licensees, successors and assigns and those acting under their permission (hereinafter "KRK"), the unrestricted, absolute, perpetual, worldwide right to:

a. use my and my minor child's name, voice, picture, portrait, artwork and/or likeness, however obtained;

b. reproduce, copy, modify, alter, edit, publish, use, create derivatives in whole or in part, without limitation, my and my minor child's image, picture, portrait, artwork and/or likeness in still and/or video photography, film or tape taken of me or my minor child by or on behalf of KRK.

c. display, exhibit, distribute, transmit or broadcast the above or any part thereof; in any project or medium, whether now or hereafter existing, including, without limitation printed publications, television, radio, the internet, any online service or website, blog or social media, including, without limitation: Twitter, Facebook, Instagram, any number of times and for any purpose, including, without limitation, promotional, advertising and marketing purposes.

2. I agree that any picture, portrait, artwork or other product or material derived there from is wholly owned by KRK and that KRK may copyright any product or material containing same. If I receive any copy thereof, I shall not use it for any purpose nor authorize its use by anyone else.

3. I hereby waive my right to inspect and/or approve the finished product or material, or to the eventual use that it might be applied.

4. I hereby release and discharge KRK from and against any claim or liability arising out of invasion of privacy, right of publicity, defamation, portrayal in a false light, misappropriation, and copyright infringement arising out of or in connection with the use of materials referenced hereunder, including without limitation the use of my or my minor child's name, voice, picture, portrait, artwork and/or likeness in any manner authorized by this Release, whether now known or arising in the future.

5. I hereby warrant that I am eighteen years old or older and am the parent and/or legal guardian of the minor child named below and am competent to contract for the minor child named herein as the above is concerned. I have read the foregoing release and warrant that I fully understand the contents hereof. I agree that this Release is intended to be as broad and inclusive as permitted under the laws of the State of Georgia, and that if any portion thereof is held to be invalid, that the balance shall continue in full force and effect.

6. This Release constitutes an Agreement between myself and KRK and contains the entire understanding between myself and KRK regarding the subject matter hereof. This Release cannot be modified except in a writing signed by all parties hereto and shall be governed in accordance with the laws of the State of Georgia.

 Child's Full Name Parent/Guardian Printed Name

 Parent/Guardian Signature Date ____/____/____

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.



Distribution • Child's File • Transportation Log

Transportation Agreement

The following information is required to be updated by Kids 'R' Kids annually and when transportation situation changes

Child's Full Name: _____

Date of Birth ___/___/___

Kids 'R' Kids _____ emergency transportation/medical procedure:

1. Call emergency medical team, if necessary
2. Contact parent/guardian (phone, email, text)
3. Contact alternate emergency contact, if necessary
4. Emergency medical team transports child to hospital.
5. Kids 'R' Kids representative will accompany child to hospital.

Emergency Medical Facility the center uses: **Stone Springs Hospital Center**

Address **24440 Stone Springs Blvd Dulles, VA, 20166** Phone **571-349-4000**

I, _____ give permission for Kids 'R' Kids **#VA1** to seek medical attention and /or transport my child _____, in the event of any emergency. I further agree to hold harmless and release Kids 'R' Kids **#VA1** and Kids 'R' Kids International, Inc. from all liability. I further agree to keep the facility informed of any changes in the information below.

For School Age Use Only: If the child relocates to another school or the hours change, this form must be updated immediately

Name of School: _____

School Address: _____

School Phone: _____

- In the event the designated location is unable to receive children they will be returned to Kids 'R' Kids _____.
- It is vital that Kids 'R' Kids _____ be notified of any changes in the above scheduled transportation.
- Kids 'R' Kids _____ will assume the above schedule of transportation will be followed unless we receive different instructions from parents in writing. Instructions should be received at Kids 'R' Kids _____ by the earliest possible time before scheduled pickup or drop off.

I, _____ agree for my child to be transported by Kids 'R' Kids _____

To school at _____ (am/pm)

From school at _____ (am/pm)

On the following days: Monday Tuesday Wednesday Thursday Friday

Parent/Guardian Signature

_____/_____/_____
Date

Owner/Director Signature

_____/_____/_____
Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.



To be Filled by Admin

Birth Certificate Verification

Child's Name _____

Child's date of birth _____

Place of birth _____

Birth certificate # _____

Person viewing document _____

Date document was viewed _____



Distribution •Child’s File •Infant/Toddler Classroom Forms •Pre-School/School-Age Classroom Forms

ChildProfile

For children ages 1 and up

A new form is required with each classroom transition

This profile will help your child’s teacher get to know your child better. Your input will also help with your child’s adjustment to the new classroom.

Child’s Full Name: _____ Date of Birth: ___/___/___

Parent/Guardian’s Name: _____
 (Please Print)

1. Listany nicknames your child may have. _____

2. Hasyour child had previous group care experiences? Yes No

3. Whatlanguage(s) is spoken in your home? _____

4. Listthe names and ages of siblings.

5. Doyou have pets at home? Yes No If yes, please list type of pet and name.

6. What words are spoken in your home to describe everyday things (I.e. toileting, nap, eat, play and outside)?

 Parent/Guardian Signature

___/___/___
 Date

This form was developed by Kids ‘R’ Kids International, Inc. It’s im portant to review State Guidelines regularly to ensure compliance.



- | |
|--|
| <p>Distribution</p> <ul style="list-style-type: none"> • Infant/Toddler Classroom Forms • Preschool/School-Age Classroom Forms • Kitchen Log • Child's File |
|--|

Child Allergy Profile

Update annually or as child's information changes

(place child's picture here)

Child's Full Name: _____ Suite: _____

Allergy To:

Symptoms of Allergic Reaction:

Emergency Care Plan:

 Parent/Guardian Signature

___/___/___
 Date

 Owner/Director Signature

___/___/___
 Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.



Kids 'R' Kids Food Preference and Allergy Form

Child's Full Name: _____

Date of Birth: _____

Classroom/Teacher: _____

1. Food Allergies

Please indicate any known food allergies:

- Peanuts
- Tree Nuts (e.g., almonds, walnuts, cashews)
- Milk/Dairy
- Eggs
- Wheat/Gluten
- Soy
- Fish
- Shellfish
- Other (please specify): _____

Severity of Reaction:

- Mild (e.g., hives, itching)
- Moderate (e.g., swelling, stomach upset)
- Severe (e.g., anaphylaxis)

Does your child carry an EpiPen? Yes No

If yes, is it provided to the school? Yes No

Please check any that apply (We don't serve pork & Beef to kids):

- Vegetarian
- Non-Vegetarian
- Religious Dietary Restrictions (please specify): _____
- Other (please explain): _____



2. Food Intolerances / Sensitivities

Please list any known food intolerances or sensitivities (e.g., lactose intolerance, gluten sensitivity):

3. Dietary Restrictions / Preferences

4. Foods to Avoid (Non-Allergy Related)

Please list any foods your child strongly dislikes or avoids:

Parent/Guardian Name: _____

Signature: _____

Date: _____

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

PLACE
PICTURE
HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
 If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM MULTIPLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW.

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

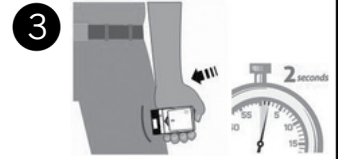
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

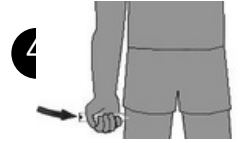
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outercase. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



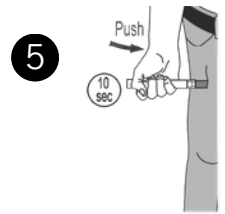
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carry tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, finger or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Acknowledgement and Receipt - Discipline and Behavior Management Policy

Praise, positive reinforcement, and redirection are often effective methods for the behavior management of children. When children receive positive, non-violent, and understanding interactions from adults and others, they develop good self-concepts, problem-solving abilities, and self-discipline. Based on this belief of how children learn and develop values, this facility will practice the following discipline and behavior management policy taken from Kids 'R' Kids, International operational guidelines and the NAEYC Code of Ethics.

Where appropriate, we will use positive reinforcement, time-away, and re-direction with children to guide children toward appropriate behavior. Guidance will be appropriate, respectful, not tied to food or toileting and within appropriate developmental expectation. At times a verbal reprimand, parent conference, or more serious discipline, up to and including dismissal, may be warranted. Corporal punishment is not permitted. We follow the NAEYC Code of Ethics – Principle-1.1: "Above all, we shall not harm children. We shall not participate in practices that are disrespectful, degrading, dangerous, exploitative, intimidating, emotionally damaging, or physically harmful to children."

Consistent application of disciplinary policies is sought, although each situation is judged on its merits, and every effort will be made to ensure that decisions are not arbitrary.

In some circumstances, a child may be placed on probation. Children who are placed on behavior probation may be required, at the School's discretion, to have their family sign a Behavior Action Plan with the School as a condition of continued enrollment. Failure to comply with the stipulations in the disciplinary probation agreement may result in dismissal.

Children may be dismissed for serious first offenses; repeat infractions (even if not related); conduct resulting in harm, damage, or disruption to the educational environment; parent or family member causing disruption to the School or the School's educational mission; non-payment of tuition or fees. Any matter taken under consideration by the Owner directly may be grounds for expulsion. **The School reserves the right to dismiss any child at the sole discretion of the School's Director or Owner.**

In addition, the School may report to the appropriate governmental authorities any actions that appear to violate law.

Acknowledgement and Receipt of Family Handbook

The registration of your child is considered an acceptance, on his/her part and on the part of his/her families or guardians, of the terms and conditions of the Family Handbook and all of our School's rules and regulations, including the School's judgment on disciplinary sanctions or dismissal of a child.

The rules and regulations contained in this Handbook are not meant to be comprehensive. Rather, they presuppose the good will and judgment of a child in all circumstances in which he/she may find himself/herself and are subject to the School's ultimate discretion, judgment and interpretation.

Children and families or guardians are asked to familiarize themselves with all of the information contained in this Family Handbook, ask questions and then sign this form.

We have read and understood all statements and provisions set forth in the Family Handbook or as they may be changed from time to time by the School.

_____	_____	_____
Child	Age	Date
_____	_____	_____
Family Member or Guardian	Relationship	Date

(School File Copy)

I, the undersigned parent or guardian of _____(print child's full name), do hereby state that I have read and received a copy of the facility's Discipline and Behavior Management Policy and that the facility's director (or other designated staff member) has discussed the facility's Discipline and Behavior Management Policy with me.

Date of Child's Enrollment: _____

Signature of Parent or Guardian: _____

Signature of Director (or designated staff member):

Distribution: One copy to parent or guardian, signed copy to be kept with child's facility records

(School File Copy)

**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 earlier 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 Code _____

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: _____ - _____ - _____

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions					
Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list Life Threatening Allergies			Diabetes: Type 2		
Allergies (seasonal)			Insulin pump		
Asthma or breathing conditions			Head injury, concussion		
Attention-Deficit/Hyperactivity Disorder			Hearing conditions or deafness		
Behavioral/Psych/ Social conditions			Heart conditions		
Developmental conditions			Lead poisoning		
Bladder conditions			Muscle conditions		
Bleeding conditions			Seizures		
Bowel conditions			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech conditions		
Cystic fibrosis			Spinal injury		
Dental Health conditions			Surgery		
			Vision conditions		

Describe any other important health-related information about your child (Feeding tube Trach Oxygen support Hearingaids Dental appliances Wheelchair, Hospitalizations, etc.):

Box 2. Medications			
List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):			
Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			
Additional Medications (Name, Dose, Time Administered, Notes)			

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)			

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 Interpreter: _____ Date ____ / ____ / ____

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM Part
II - Certification of Immunization**

Check if the student's Immunization Records are attached using a separate form signed by HCP	<input type="checkbox"/>
--	--------------------------

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name:	Date of Birth : / /	Sex:
Race (Optional):	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
	1	2	3	4	5
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)					
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)					
Tdap Vaccine booster					
Poliomyelitis vaccine (IPV, OPV)					
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age					
Rotavirus Vaccine (RV) only for children < 8 months of age					
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age					
Varicella Vaccine					
Measles, Mumps, Rubella Vaccine (MMR vaccine)			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles Vaccine (Rubeola)					
Rubella Vaccine			Serological Confirmation of Measles Immunity:		
Mumps Vaccine			Serological Confirmation of Rubella Immunity:		
Hepatitis B Vaccine (HBV)			Serological Confirmation of Mumps Immunity:		
<input type="checkbox"/> Merck adult formulation used					
Hepatitis A Vaccine					
Meningococcal ACWY Vaccine					
Meningococcal B Vaccine					
Human Papillomavirus Vaccine (HPV)					
Influenza (Yearly)					
Other					
Other					

Certification of Immunization	
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 <i>Regulations for the Immunization of School Children</i> (Reference Section III).	
Signature of Medical Provider or Health Department Official:	Date (Mo., Day, Yr) / /

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |__|_|_|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

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																																																											
		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td><td align="center">1</td><td align="center">2</td><td align="center">3</td><td></td><td align="center">1</td><td align="center">2</td><td align="center">3</td><td></td><td align="center">1</td><td align="center">2</td><td align="center">3</td> </tr> <tr> <td>HEENT</td><td></td><td></td><td></td><td>Neurological</td><td></td><td></td><td></td><td>Skin</td><td></td><td></td><td></td> </tr> <tr> <td>Lungs</td><td></td><td></td><td></td><td>Abdomen</td><td></td><td></td><td></td><td>Genital</td><td></td><td></td><td></td> </tr> <tr> <td>Heart</td><td></td><td></td><td></td><td>Extremities</td><td></td><td></td><td></td><td>Urinary</td><td></td><td></td><td></td> </tr> </table>													1	2	3		1	2	3		1	2	3	HEENT				Neurological				Skin				Lungs				Abdomen				Genital				Heart				Extremities				Urinary			
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	HEENT				Neurological				Skin																																																				
Lungs				Abdomen				Genital																																																					
Heart				Extremities				Urinary																																																					
Tuberculosis Screening Check the box that applies: <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified																																																													
	Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																												

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

Blood Lead: _____ Hct/Hgb _____

Developmental Screen	<i>Assessed for:</i>	<i>Assessment Method:</i>	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>																		
	Emotional/Social																						
	Problem Solving																						
	Language/Communication																						
	Fine Motor Skills																						
Screening	Screened at 20dB: Indicate Pass (P) or Refer (R) in each box. Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Referred																						
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td><td align="center">1000</td><td align="center">2000</td><td align="center">4000</td><td></td><td></td> </tr> <tr> <td>R</td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>L</td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						1000	2000	4000			R						L					
		1000	2000	4000																			
R																							
L																							
<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: <input type="checkbox"/> Left <input type="checkbox"/> Right Hearing aid or another assistive device																							

Vision Screen	<input type="checkbox"/> With Corrective Lenses (Check if yes)													
	Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested													
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Distance</td><td align="center">Both</td><td align="center">R</td><td align="center">L</td><td>Test used:</td> </tr> <tr> <td></td><td align="center">20/</td><td align="center">20/</td><td align="center">20/</td><td></td> </tr> </table>					Distance	Both	R	L	Test used:		20/	20/	20/
Distance	Both	R	L	Test used:										
	20/	20/	20/											
	<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test-needs rescreen													

Scrub Dental	<input type="checkbox"/> Problems Identified: Referred for Treatment
	<input type="checkbox"/> No Problem: Referred for prevention
	<input type="checkbox"/> No Referral: Already receiving dental care
	<input type="checkbox"/> Unable to perform

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to school or physical activity (complete sections below and/or explain here):
	Allergy: <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____
	Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
	Restricted Activity Specify: _____
	Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____
	Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> 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) <input type="checkbox"/> 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: _____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____



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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT and CREDIT CARD(3% credit charges)**

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card) (3% credit card charges**)

Cardholder Name	Phone #
CardholderAddress	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

SECTION B (Bank Account)

Your Name	Phone #			
Address	City State Zip			
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	

Authorized Signature	Date
----------------------	------

For Official Use Only

Date Received
Employee Signature



A service of

