Kids R Kids Learning Academy of South Riding

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_____ ☐ Parent ☐ Guardian

Home Address _____ Home Phone _____

_____ Cell Phone _____

Email _____

Place of Employment _____ Business Phone _____

Employment Address _____

Parent/GuardianName_____ ☐ Parent ☐ Guardian

HomeAddress_____ Home Phone _____

_____ Cell Phone _____

Email_____

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 Date

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

KRK/REV/04/2022

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? ☐ Yes ☐ No
Specify: _____

Does your child have allergies? ☐ Yes ☐ No

Is your child on prescribed medication for Illness/Allergies? ☐ Yes ☐ 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

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

Distribution
• Child's File

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

1. Kids 'R'Kids#_____agreestoprovidechildcarefor_____onM–Tu–W–Th–F
2. from _____amto_____pm. Child's Full Name
3. I agreetopaythetuitionfeeof$_____asdesignatedbytheschoolaswellasaregistrationfeeof$_____ that willbedueannually.Paymentwillbedueon_____.
   My childiscurrentlyonmedication(s)prescribedforlong-termcontinuoususeand/orhasthefollowingpre-existing illness, allergies, or health concerns: _____
   _____.
   I agreetoprovidetheschoolwithallnecessaryinformationpertainingtotheadministeringofmedication(date, prescription #, Allergy Action Plan, doctor's notes, direction, medication in original pharmaceutical container, etc.).
4. I agreetofollowallrequirementsoftheschool'smedicalpolicy.
5. My childhasthefollowingspecialneedsthatmayaffectparticipationinschoolactivities:_____
6. _____.
   The followingspecialaccommodation(s)mayberequiredtomosteffectivelymeetmychild'sneedswhileatthis
7. school: _____.
8. I understandmychildwillbeprovidedwithallsnacksandlunchserveddailyduringhis/herhoursofattendance.
   I understandIamresponsibleforanyspecialdietrequiredbymychildandwillprovideadoctor'snoteindicating 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 mychildwearsdiapers,IunderstandIwillprovidewhateverdisposablediapersarenecessaryformychild.I understand that only disposable diapers are permitted in the school and that they will be changed every two hours, or asneeded.
10. If childisofschoolage,whatschooldoeshe/sheattend:_____.
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 fieldtrip.
12. I giveconsentformychildtoparticipateinthefollowingwateractivities: ☐watertableplay, ☐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 asnecessary.(Theparent/guardianwillassumeresponsibilityforpayment).
14. I understandthatifmychildisill,including,butnotlimitedto,aseverecoughorsorethroat,undeterminedrash or spots,temperatureover_____degrees,severeheadaches,upsetstomachordiarrhea,heorshecannotbe 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'Kidswillnotifyparentsifanotifiablediseasehasbeenintroducedintotheschoolandguidelineswillbe followed per the CDC Chart/Health Dept.
15. I understandthatKids'R'Kids#_____aKids'R'Kidsfranchise,isindependentlyownedandoperatedandthat neither Kids 'R' Kids International, Inc. nor any other Kids 'R' Kids is responsible for the actions or obligations of this school.
16. I understandthatitismyresponsibilitytoescortmychildintoandoutoftheschool.Andtosignmychildinand 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 beupdated by Kids 'R' Kids annually and when transportationsituation changes

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

Kids 'R' Kids_____VA1_____ emergency transportation/medical procedure:

1. Call eme rgency 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.

KRK/REV/02/2020

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.

Distribution
- 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'spicture 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.

KRK/REV/12/2019

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: _____

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

Name: _____ **D.O.B.:** _____

Allergic to: _____

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

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

PLACE PICTURE HERE

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, evenifnosymptomsareapparen

FORANYOF THE FOLLOWING:

SEVERESYMPTOMS

LUNG
Shortnessof breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tightor hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hivesover 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.**

MILDSYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchymouth

SKIN
Afew hives, mild itch

GUT
Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE 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): _____

_____

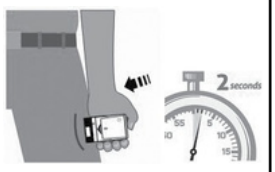
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE **DATE** **PHYSICIAN/HCP AUTHORIZATION SIGNATURE** **DATE**

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

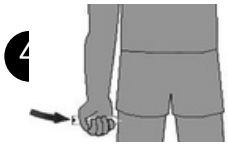
FARE
Food Allergy Research & Education

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



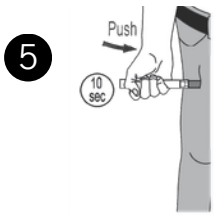
1. **RemoveAuvi-Q from the outercase. Pull off red safety guard.**
2. **Place black end of Auvi-Q against the middle of the outer thigh.**
3. **Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.**
4. **Call 911 and get emergency medical help right away.**

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 theclearcarriertube.**
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 theyellow or green cap off of theauto-injectorin the direction ofthe"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 toexpose 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 notput your thumb, fingersor hand over the tip of the auto-injectoror 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:** _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

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		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

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

Box2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	TimeAdministered (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.***

Signatureof Parent orLegalGuardian: _____ 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 ☐

Section I

See Section II for conditionalenrollment and exemptions.

A copy of the immunization record signed or stamped by aphysician or designee,registered nurse, or healthdepartment 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.

StudentName: **DateofBirth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

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

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** inaccordance with the MINIMUM requirements for attending school, child care or preschool prescribedbytheStateBoardofHealth's *Regulations for the Immunization of School Children* (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 forEntryintoSchoolandDayCare,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				

Tuberculosis Screening

Check the box that applies:

☐ ☐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: ☐ Negative ☐Positive

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				

Screening

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

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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:**_____

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

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

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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 _____

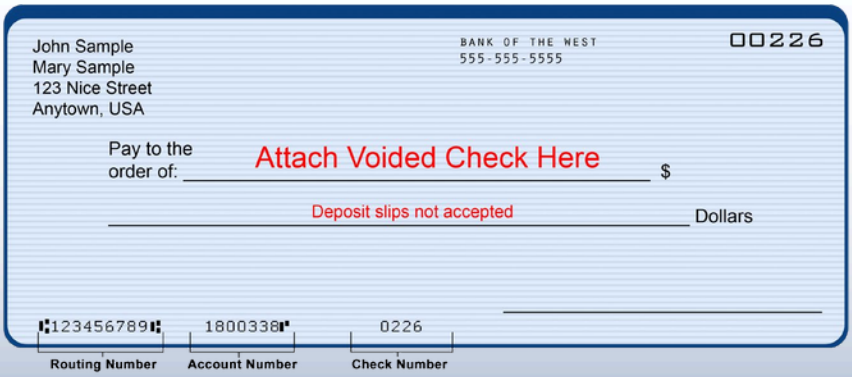
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
_____
Employee Signature
_____



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