

## 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/Guardian Name \_\_\_\_\_ ☐ Parent ☐ Guardian

Home Address \_\_\_\_\_ 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

**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 of 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 \_\_\_\_\_ VA1 \_\_\_\_\_ 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.*

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**

- Infant/Toddler Classroom Forms
- Front Desk Forms

(Month) \_\_\_\_\_

## Infant Feeding Plan

For children ages 6weeks-12 months

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Instructions to Parents/Guardians:**

- Bottles must be pre-mixed (if applicable), labeled with child's full name, current day's date and ready to be served.
- Breast milk must be prepared and stored in a bottle ready for use with the amount of milk for one feeding, labeled with the child's full name, and date of collection. \*frozen storage bags are not permitted.
- Update diet information as needed or every 30 days. Use a new form or initial/date changes on this form.

Does child feed self? ☐ Yes ☐ No

Child's diet includes (check all that apply):

|             |                          |                |                          |
|-------------|--------------------------|----------------|--------------------------|
| Formula     | <input type="checkbox"/> | Juice          | <input type="checkbox"/> |
| Breast Milk | <input type="checkbox"/> | Baby Foods     | <input type="checkbox"/> |
| Whole Milk  | <input type="checkbox"/> | Strained Foods | <input type="checkbox"/> |
| Water       | <input type="checkbox"/> | Table Foods    | <input type="checkbox"/> |

Formula type: \_\_\_\_\_

Bottle's Formula Amount: \_\_\_\_\_

Breast Milk Storage: ☐ Bottles

Bottle's Breast Milk Amount: \_\_\_\_\_

Food Likes: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Allergies: \_\_\_\_\_

Restrictions: \_\_\_\_\_

List any commercial premixed formula that may not be used in an emergency due to food allergies: \_\_\_\_\_

| Feeding | Time of Day | Type and Approximate Amount of Food |
|---------|-------------|-------------------------------------|
|         |             |                                     |
|         |             |                                     |
|         |             |                                     |
|         |             |                                     |
|         |             |                                     |

**Additional Instructions** (i.e. for the introduction of solid foods, dietary changes):

---

---

---

---

---

I understand it is my responsibility to keep Kids 'R' Kids # \_\_\_\_\_ updated, in writing, as my child's needs change or **every 30 days**, and that it is Kids 'R' Kids policy that bottles are held, not propped, during feeding & that bottles are discarded within an hour after warmed. Unused breast milk will be sent home. Not discarded.

\_\_\_\_\_  
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.*

KRK/REV/5/2026

**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

**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'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

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, 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 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

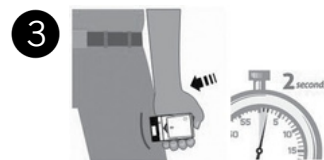
Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

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

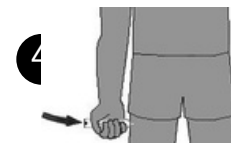
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



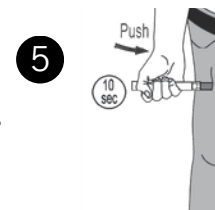
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrying 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.

|                                    |                       |               |
|------------------------------------|-----------------------|---------------|
| _____<br>Child                     | _____<br>Age          | _____<br>Date |
| _____<br>Family Member or Guardian | _____<br>Relationship | _____<br>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 <b>Life Threatening Allergies</b> |     |          | 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.):

| Box2. 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

☐

**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.

|                         |  |                                                                                           |  |             |  |
|-------------------------|--|-------------------------------------------------------------------------------------------|--|-------------|--|
| <b>Student Name:</b>    |  | <b>Date of Birth :</b> /      /                                                           |  | <b>Sex:</b> |  |
| <b>Race (Optional):</b> |  | <b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> 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                                                                      |                                                                 |   |                                                                              |   |   |
| 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 |                                                                              |   |   |
| Rubella Vaccine                                                                           | 1                                                               | 2 | Serological Confirmation of Measles Immunity:                                |   |   |
| Mumps Vaccine                                                                             | 1                                                               | 2 | Serological Confirmation of Rubella Immunity:                                |   |   |
| Hepatitis B Vaccine (HBV)                                                                 | 1                                                               | 2 | Serological Confirmation of Mumps Immunity:                                  |   |   |
| <input type="checkbox"/> Merck adult formulation used                                     | 1                                                               | 2 | 3                                                                            | 4 |   |
| 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** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

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

## 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](http://www.vahealth.org/schoolhealth).

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: ☐ M ☐ F

|                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                     |                                                                                                                      |   |   |              |   |   |   |         |   |   |   |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---|---|--------------|---|---|---|---------|---|---|---|--|--|--|--|
| <b>Health Assessment</b>                                                                                                                                                                                                                                                                                     | <b>Date of Assessment:</b> ____ / ____ / ____<br>Weight: ____ lbs. Height: ____ ft. ____ in.<br>Body Mass Index (BMI): ____ BP ____<br>Age / gender appropriate history completed<br>Anticipatory guidance provided | <b>Physical Examination</b><br>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 |   |   |   |  |  |  |  |
| <b>Tuberculosis Screening</b><br>Check the box that applies:<br><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<br>CXR required if positive test for TB infection or TB symptoms.    CXR Date: ____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |                                                                                                                                                                                                                     |                                                                                                                      |   |   |              |   |   |   |         |   |   |   |  |  |  |  |
| <b>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b><br>Blood Lead: ____    Hct/Hgb ____                                                                                                                                                                                 |                                                                                                                                                                                                                     |                                                                                                                      |   |   |              |   |   |   |         |   |   |   |  |  |  |  |

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

|                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |     |     |                                     |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----|-----|-------------------------------------|------------------------------------------------------------------------|--|--|--|-------------------------------------|----------|------|---|---|------------|--|-----|-----|-----|--|--|--|--|
| <b>Vision Screen</b>                                                                                                                                                                                                                                      | <input type="checkbox"/> With Corrective Lenses (Check if yes)                                                                                                                                                                                                                                                                                                                                                                                     |      |     |     |                                     |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |
|                                                                                                                                                                                                                                                           | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4">Stereopsis <input type="checkbox"/> Pass    <input type="checkbox"/> Fail</td> <td><input type="checkbox"/> Not tested</td> </tr> <tr> <td>Distance</td> <td>Both</td> <td>R</td> <td>L</td> <td rowspan="3">Test used:</td> </tr> <tr> <td></td> <td>20/</td> <td>20/</td> <td>20/</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table> |      |     |     |                                     | Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail |  |  |  | <input type="checkbox"/> Not tested | Distance | Both | R | L | Test used: |  | 20/ | 20/ | 20/ |  |  |  |  |
|                                                                                                                                                                                                                                                           | Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail                                                                                                                                                                                                                                                                                                                                                                             |      |     |     | <input type="checkbox"/> Not tested |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |
|                                                                                                                                                                                                                                                           | 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                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |     |     |                                     |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |
| <b>Scrub Dental</b>                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |     |     |                                     |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |
| <input type="checkbox"/> Problems Identified: Referred for Treatment<br><input type="checkbox"/> No Problem: Referred for prevention<br><input type="checkbox"/> No Referral: Already receiving dental care<br><input type="checkbox"/> Unable to perform |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |     |     |                                     |                                                                        |  |  |  |                                     |          |      |   |   |            |  |     |     |     |  |  |  |  |

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b> | <b>Summary of Findings (check one):</b><br><input type="checkbox"/> Well child; no conditions identified of concern to school program activities<br><input type="checkbox"/> Conditions identified that are important to school or physical activity (complete sections below and/or explain here):                                                                                                                                |  |
|                                                                                     | <b>Allergy:</b> <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____<br>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: _____ |  |
|                                                                                     | <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)                                                                                                                                                                                                                                                                                                                      |  |
|                                                                                     | <b>Restricted Activity Specify:</b> _____                                                                                                                                                                                                                                                                                                                                                                                          |  |
|                                                                                     | <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____                                                                                                                                                                                                                                                                                                     |  |
|                                                                                     | <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.                                                                                                                                                                                                                                                                            |  |
|                                                                                     | <b>Special Diet Specify:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                                                                     | <b>Special Needs Specify:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                |  |
|                                                                                     | <b>Other Comments:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                       |  |

|                                                                                                                                                                                                                                                                               |                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| <b>Health Care Professional's Certification (Write legibly or stamp)</b> <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). |                                                    |
| <b>Name:</b> _____                                                                                                                                                                                                                                                            | <b>Signature:</b> _____                            |
| <b>Practice/Clinic Name:</b> _____                                                                                                                                                                                                                                            | <b>Address:</b> _____                              |
| <b>Phone:</b> ____ - ____ - ____                                                                                                                                                                                                                                              | <b>Fax:</b> ____ - ____ - ____ <b>Email:</b> _____ |



## Automated Payment Processing Safe – Convenient – Easy

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 #         |
| Cardholder Address   | 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

|                                                               |                                  |              |
|---------------------------------------------------------------|----------------------------------|--------------|
| John Sample<br>Mary Sample<br>123 Nice Street<br>Anytown, USA | BANK OF THE WEST<br>555-555-5555 | 00226        |
| Pay to the order of:                                          | Attach Voided Check Here         | \$           |
|                                                               | Deposit slips not accepted       | Dollars      |
| 123456789                                                     | 1800338                          | 0226         |
| Routing Number                                                | Account Number                   | Check Number |

A service of

