creative wonders
LEARNING CENTER

Enrollment Checklist

_____
Child's Name

- o Registration Form
- o Immunization Records
- o Physical/Well Check Up
- o School Entrance Health Form
- o Communicable Disease Form
- o Photograph Permission Form
- o Internet Photo Release Form
- o Topical Form
- o Gym Permission Form
- o Infant Formula Waiver Form
- o CACFP Income Eligibility and Enrollment Form

- o Social Services Worker: _____ Phone Number _____
- o Entered in CPU by: _____
- o Billing Amt/Frequency: _____
- o Start Date: _____
- o End Date: _____
- o Time Clock Code: _____
- o Emergency Sheet to Teacher: _____
- o Faxed Date: _____
- o Recd Date: _____
- o School Attending_____
- o Grade Level_____
- o Added to Van List_____
- o Daily Connect_____
- o Email Address_____

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Child Care Registration Form

Date child entered care	Date child left care

Child's name Last First Middle	Name (Nickname) used	Birthdate

Street address City Zip code

Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -

Street address City Zip code

Address where you can be reached while child is in care City Zip code

Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -

Street address City Zip code

Address where you can be reached while child is in care City Zip code

Other than you, who else has permission to pick up your child?

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code
Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.	
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.	
Child's dentist's name		Telephone number ( ) -
Street address	City	Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee_____,

Address of Licensee_____.

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

AGREEMENTS

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

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

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

SIGNATURES

_____ _____

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

_____ _____

Administrator of Center *Date*

Date Child Entered Care: _____ Date Left Care: _____

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

OFFICE USE ONLY
IDENTITY VERIFICATION

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

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

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

_____

Date

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

Section 63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding,. (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means.

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

Part I – HEALTH INFORMATION FORM

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

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

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

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

Name of Mother or Legal Guardian: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

Name of Father or Legal Guardian: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

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

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

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

_____

_____

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

_____

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

Please provide the following information:

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

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

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

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

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

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

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COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

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

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

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

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

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

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

Section II
Conditional Enrollment and Exemptions

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

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

_____

_____

_____.

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

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

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

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

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

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

Section III
Requirements

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/____

Weight: _____lbs. Height: _____ft. _____in.

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: _____ mm

Physical Examination

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

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

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

Blood Lead: _____ Hct/Hgb _____

Developmental Screen

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

Hearing Screen

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

	1000	2000	4000
R			
L			

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

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

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

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

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

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

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

Summary of Findings (check one):

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

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

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

Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epi pen ☐ other: _____

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

___ **Restricted Activity** Specify: _____

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

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

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp):

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

Practice/Clinic Name: _____ Address: _____

Phone: ___-___-_____ Fax: ___-___-_____ Email: _____

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SHARING INFORMATION WITH MEDICAID/SCHIP (FAMIS in Virginia)

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP)or (FAMIS in Virginia). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and FAMIS that your children are eligible for free or reduced price meals, *unless you tell us not to.*** Medicaid and FAMIS only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

☐ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program (FAMIS).

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

_____

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Parental/Guardian Consent Form

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personally identifiable information to be published on the district and/or school's web site.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, e-mail address, phone numbers and locations and times of class trips.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

Check one of the following choices:

- ❑ I/We GRANT permission for a photo/image that includes this student without any other personal identifiers to be published on the school and/or district's public Internet site.
- ❑ I/We GRANT permission for this student's photo/image and name to be published on the school and/or district's public Internet site.
- ❑ I/We GRANT permission for this student's photo/image and all other personal identifiers listed above to be published on the school and/or district's public Internet site.
- ❑ I/We DO NOT GRANT permission for photo/image that includes this student to be published on the school and or district's public Internet site.

Student's Name: (please print) _____ Student's Grade: _____

Print name of Parent/Guardian: (print) _____

Signature of Parent/Guardian: (sign) _____

Relation to Student: _____

Date: _____

Topical Lotion/Medication Permission Form

I hereby give you, _____, permission to use the

(Name of Child Care Program)

following on following on my child, _____, when

(Name of Child)

appropriate.

____ Sunscreen

____ Insect Repellent

____ Desitin/ A&D

____ First Aid cream/lotion/spray

____ Sunburn relief spray/lotion/gel

____ Vaseline

____ Teething reliever

____ Hand lotion

____ Other _____

____ Other _____

_____ _____

(Parent/Guardian Signature) (Date)