



# creative wonders

## LEARNING CENTER

### Enrollment Checklist

Child's Name \_\_\_\_\_

- Registration Form
- Immunization Records
- Physical/Well Check Up
- School Entrance Health Form
- Communicable Disease Form
- Photograph Permission Form
- Internet Photo Release Form

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- Topical Form
- Gym Permission Form
- Infant Formula Waiver Form
- CACFP Income Eligibility and Enrollment Form
  
- Social Services Worker: \_\_\_\_\_ Phone Number \_\_\_\_\_
- Entered in CPU by: \_\_\_\_\_
- Billing Amt/Frequency: \_\_\_\_\_
- Start Date: \_\_\_\_\_
- End Date: \_\_\_\_\_
- Time Clock Code: \_\_\_\_\_
- Emergency Sheet to Teacher: \_\_\_\_\_
- Faxed Date: \_\_\_\_\_
- Recd Date: \_\_\_\_\_
- School Attending \_\_\_\_\_
- Grade Level \_\_\_\_\_
- Added to Van List \_\_\_\_\_
- Daily Connect \_\_\_\_\_
- Email Address \_\_\_\_\_

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: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Middle 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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**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: 

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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 (6 <sup>th</sup> grade entry)	1				
*Polio (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) <input type="checkbox"/> 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.): \_\_\_\_ / \_\_\_\_ / \_\_\_\_



### 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>	Date of Assessment: ____/____/____	<b>Physical Examination</b>										
	Weight: ____ lbs. Height: ____ ft. ____ in.	1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment										
	Body Mass Index (BMI): ____ BP ____	1	2	3	1	2	3					
<input type="checkbox"/> Age / gender appropriate history completed	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anticipatory guidance provided	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB Risk Assessment: <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mantoux results: _____ mm	EPSDT Screens <u>Required</u> for Head Start – include specific results and date:											
Blood Lead: _____ Hct/Hgb _____												

<b>Developmental Screen</b>	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
Gross Motor Skills					

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ____ Left ____ Right <input type="checkbox"/> Hearing aid or other assistive device		
		1000	2000	4000			
	R						L
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer							

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Not tested		
	Distance	Both	R	L	
					<b>Dental Screen</b>
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen					
<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care					

<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings (check one):</b>	
	<input type="checkbox"/> Well child; no conditions identified of concern to school program activities	
	<input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____	
	_____	
	_____	
	Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____	
	Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____	
	Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	Restricted Activity Specify: _____	
	Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.		
Special Diet Specify: _____		
Special Needs Specify: _____		
Other Comments: _____		

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



# 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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)