Student Registration Packet

Messiah United Methodist Church
408 Dominion Commons Way
Chesapeake, VA 23322
(757)549-1824

messiahpreschool@gmail.com
www.messiahchurchpreschool.org
www.facebook.com/MessiahPreschool

Enrollment Checklist

2024-2025

Student Name _____ Enrollment Date _____

The following enrollment forms must be received in order to secure a place at Messiah Preschool:

_____ Student Registration, Information & Photo Release Form
_____ Emergency Medical Authorization
_____ Tuition and Fees Agreement
_____ Program Decision to Administer Medications Form
_____ VA School Entrance Health Form
_____ Immunization Record
_____ Copy of Birth Certificate or other Proof of Identification
_____ Non-Refundable Registration Fee by Check or Cash

Messiah Preschool uses the **Remind App** for parent communication. This summer, please add the Remind App to your phone using this link: **rmd.at/messiahp**

The 2024-2025 school year operates from the second Monday in September through the Friday before Memorial Day in May. School hours are from 9:00am to 12:00pm.
Stay & Play is offered on select dates until 1:30pm for an additional fee.

Messiah Preschool generally follows the Chesapeake Public School calendar for most holidays.

In addition to the CPS holidays and teacher workday closings, Messiah dismisses the full day before Thanksgiving, may dismiss additional days before Christmas and observes Good Friday.

Messiah Preschool Overview

2024-2025

Messiah Preschool opened its doors to the community in 1989 as an outreach ministry of the Messiah United Methodist Church. Our philosophy is to welcome children into a quality early childhood educational program based upon Christian principles and values. For more than thirty years, our school has maintained a reputation as a highly desirable preschool program with personalized attention to the needs of every child and family. We strive to provide an environment where each child develops self-esteem, independence and experiences academic success.

We offer a safe learning and nurturing Christian atmosphere where our primary goal is to enhance each child's cognitive, social, physical and spiritual development through play and age appropriate curriculum. At Messiah Preschool we understand that every child is a "Gift from God" and we are privileged to be entrusted with guiding their young minds to discover the world around them.

Messiah Preschool operates daily from the second Monday in September through the Friday before Memorial Day in May. Our hours are from 8:50 am to 12:00 pm. In addition to the program Director, each classroom is instructed by a qualified teacher and teaching assistant. All staff members are certified in CPR and First Aid.

Messiah Preschool Programs:

The Two-year old program is designed to provide a loving and nurturing transition from your home to a school group setting for older two's. They will engage in activities designed to improve communication and language skills, independent self care and hygiene, and gross and fine motor skills. Daily activities include free play, art, stories, music, finger plays, prayer and circle time. Children must be 2.5 years old to attend and are not required to be potty trained. Exceptions to the age requirement can be discussed with the Director.

The Three-year old program encourages both large and small group activities. The children learn to interact cooperatively with others and are offered various classroom activities that will develop their social, cognitive and fine motor skills. They will become independent in self-care and hygiene, and must be potty trained in order to attend. The curriculum introduces the alphabet, colors, shape recognition, counting, patterns and rhythms, and simple science concepts. Activities include free play and teacher directed learning centers, circle time, music, art, and daily prayer.

The Three day Four-year-old program introduces social and academic skills to prepare the children for a positive kindergarten experience. This is accomplished through self-expression, free & dramatic independent play, decision making and developing routines. Cognitive activities include reading readiness, which is accomplished through alphabet and letter sounds, as well as math concepts such as recognizing numbers, colors and shapes. In addition, language and listening skills are emphasized along with basic science concepts and introductory handwriting.

The Pre-Kindergarten program prepares the child for academic success in kindergarten. The benefits of additional days in Pre-K include an introduction to emergent reading skills, a deeper understanding of the alphabet, letter sounds, numbers 1-20, writing skills and simple science and math concepts. They will continue to develop both fine and gross motor skills. The children are encouraged to work independently, respect authority, and interact cooperatively with peers. Free play and directed centers reinforce weekly curricular themes based on Virginia's Early Learning and Development Standards, Birth - Five Learning Guidelines. The children also participate in a weekly music class.

All students ages three and above should be completely potty independent and will not be allowed to attend school in a pull-up or diaper.

Student Registration Form

2024-2025

Identity Verification
Office Use Only

Birth Certificate Number
Date Issued | ** Staff Initial **

Class requested: 2 yr. old – 2 day _____ (Age 2 by April 1st) 3 yr. old – 2 day ____ 3 yr. old – 3 day _____
3 yr. old – 5 day _____ 4 yr. old - 3 day _____ Pre-K 4 yr. old – 5 day _____

Children in our Three's and Four's classes must meet the designated age by September 30th and must be fully potty trained.

Student Name _____ Date of Birth _____
Last First Middle
Address _____

Home telephone #_____ Neighborhood/Subdivision _____

Child's Primary Residence: Both Parents _____ Mom Only _____ Dad Only _____ Other _____

Parent (1) Name _____ Primary Email _____
Cell Phone # _____ Work Number _____
Address (if different from child) _____

Parent (2) Name _____ Email _____
Cell Phone #_____ Work Number _____
Address (if different from child) _____

Siblings (Age): _____

Child's Caregiver: Name _____ Telephone # _____
(If your child goes there before or after preschool on a regular basis)

Please list allergies, special needs pertaining to your child: ❒ EpiPen ❒ Inhaler
_____

Besides parents, please list names and phone # of those authorized to pick up child:
_____ Phone _____
_____ Phone _____

Student Information & Photo Release

Throughout the school year, we often see the children happily at play and wish to share those moments with you. Also, many parents wish to arrange play dates or carpool with their children's classmates. Please see the consent agreements below regarding your necessary permission.

I give the staff of Messiah Methodist Preschool permission to take candid pictures of my child while he/she is playing and to display them on the premises or share them on the Messiah Facebook Page. YES _____ NO _____

I give my permission to have my child's name, address, telephone number and email address, as well as the name of parents, printed on a roster and distributed among the preschool class. YES _____ NO _____

Signature of Parent/Guardian _____ Date _____

Referred by _____

Emergency Medical Authorization & Medical Release Agreement

Student Name _____ Date of Birth _____

Allergies or Medical Conditions: _____

Name of Parent(s)/Guardian(s) _____

Home Address _____

Email Address _____

cell # (mother)_____ cell # (father)_____

cell # (caregiver/other)_____

I/We will be responsible for payment of medical care expenses. _____ (Please initial)

Medical treatment costs are covered by:
Insurance Carrier (Name and Policy #) _____
Name of Policy Holder _____
Child's Physician _____ Phone # _____
Child's Dentist _____ Phone # _____

1. Messiah Preschool 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 preschool.
2. The parent(s)/guardian(s) authorize Messiah Preschool to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. *
3. The parent(s)/guardian(s) agree to inform the center within 24 hours or the next business day after the child/student or any member of the immediate family has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

I agree with and will abide by the policies set forth in the Messiah Preschool Parent Handbook.

***If an emergency occurs when I cannot be contacted immediately,**
I, (parent/guardian) _____ authorize Messiah Preschool to obtain immediate medical care for and consent to the hospitalization of; the performance of necessary diagnostic tests; the use of surgery on; and/or the administration of drugs to:

_____
(Name of Child or Ward)

(It is also understood that this agreement covers only those situations which are true emergencies and only when the parent/guardian cannot be reached. Otherwise, the parent/guardian expects to be notified immediately.)

Please print name _____

Signature: _____ Date: _____

Tuition and Fees Agreement

2024-2025

Student Name _____

The Registration Fee and annual Tuition rated are as follows:
Registration Fee (cash or check only) ❒ $175 (beginning March 1) ❒ $150 Early Bird (until February 29)

Select Preferred Class

❒ 2-year-olds	Tuesday and Thursday	Tuition - $2187/yr or $243/month
❒ 3-year-olds	Tuesday and Thursday	Tuition - $2187/yr or $243/month
❒ 3-year-olds	Monday-Wednesday-Friday	Tuition - $2457/yr or $273/month
❒ 3-year-olds	Monday through Friday	Tuition - $2907/yr or $323/month
❒ 4-year-olds	Monday-Wednesday-Friday	Tuition - $2457/yr or $273/month
❒ Pre-Kindergarten	Monday through Friday	Tuition - $2907/yr or $323/month

I agree to pay the tuition specified herein for the above student and acknowledge the following:

- **Tuition is always due on the 1st day of each month.**
- **Tuition invoices are emailed and payments are made electronically through bank transfer.**
- **Credit card payments are also accepted with an added fee of 3% (Please notify director if you desire this option).**
- **A $25.00 late fee will be assessed for any tuition not received by the 10th of the month.**
- **A $35.00 fee will be assessed for any returned payments.**

I understand that I am responsible for the tuition charged for my child to attend preschool.
According to the Parent Handbook, I agree to provide the Director of Messiah Preschool a 30 day advance, written notice from the next billing date, of intent to withdraw a child from Messiah Preschool. If I fail to provide such notice, one month's full tuition will be due. Absence from the classroom does not constitute withdrawal from the preschool.

Messiah Preschool follows the Chesapeake Public Schools calendar for most closings (weather-related, teacher work days, holidays, etc.) In addition to the CPS holidays and teacher workday closings, Messiah dismisses the full day before Thanksgiving, may dismiss additional days before Christmas and observes Good Friday. If CPS closes for inclement weather, Messiah Preschool will also close. If CPS is delayed one hour, Messiah Preschool will open at 10:00am. If CPS is delayed two hours, Messiah Preschool will be closed for the day. Messiah Preschool does not have a make-up day policy. Tuition will not be refunded/prorated for inclement weather or any other unforeseen circumstances.

I understand that Messiah Preschool is a nonprofit organization that relies completely on tuition to pay operating expenses. If tuition payments cannot be made because of an emergency situation, I must inform the Director immediately so that a plan can be agreed upon to resolve tuition payments.

Non-payment of tuition over 30 days may result in the dismissal of the child from Messiah Preschool. Should I fail to pay the required tuition payments, the school may find it necessary to forward our account to a collection agency for payment.
I understand that the **registration fee is non-refundable**, and that my regular monthly payments, as noted above, are required for my child to remain in Messiah Preschool.

Please print name _____

Signature: _____ Date: _____

Religiously Exempt Child Day Center
Program Decision to Administer Medications

Messiah Preschool has made the following decision regarding the administration of medications to a child in our program:

I (or my staff) WILL administer the emergency injection of epinephrine (using an auto-injector device) and emergency inhalers.
We will not administer ANY other medications.

*Please sign below acknowledging that you understand our policy regarding administration of medication.

Provider's Name (please print): Kerry Gionis	Facility Name: Messiah Preschool
Provider's Signature: Kerry Gionis	Date: 1/31/24
Parent's Signature:	Date:

Authorized Staff to Administer emergency injection of epinephrine using an auto-injector device

Messiah Preschool will administer an emergency injection of epinephrine using an auto-injector device in accordance with the physician's or other prescriber's instructions and in accordance with the standards of practice in the EMAT training. Only a provider who has successfully completed the EMAT training or has appropriate licensure to administer an emergency injection of epinephrine and is listed as a medication administrator in the Program's Decision Regarding Medication Plan will be permitted to administer an emergency injection of epinephrine at Messiah Preschool.
I understand that any individual listed in this section as a medication administrator is approved to administer epinephrine using the following routes: epinephrine using an auto-injector device.
I understand that to be approved to administer prescription medication, all individuals listed in my PROGRAM'S DECISION REGARDING MEDICATION plan (unless the individual is licensed to administer prescription medications) must have a valid:

- Emergency Medication Administration Training (EMAT) certificate;
- CPR certificate which covers all ages of the children at Messiah Preschool listed on our registration/license; and
- First aid certificate which covers all ages of children Messiah Preschool is approved to care for as listed on our registration/license.

Emergency Medication Administrator(s)
EMAT certificates (or documentation of licensure to administer epinephrine using an auto-injector device), age appropriate first aid certificates, and CPR certificates for the staff listed below will be kept on site and be available upon request.
Provider/Staff Name: Kerry Gionis (and other trained staffed)

Confidentiality Statement

Information about any child in our program is confidential and will not be given to anyone except VDOE designees or other persons authorized by law unless the child's parent or guardian gives written permission. Information about a child in our program will be given to the local department of social services if the child received a day care subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

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: ____/____/_____

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:** _____

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: ____/____/_____

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:** _____