

# Student Registration Packet



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

[messiahpreschool@gmail.com](mailto:messiahpreschool@gmail.com)  
[www.messiahchurchpreschool.org](http://www.messiahchurchpreschool.org)  
[www.facebook.com/MessiahPreschool](https://www.facebook.com/MessiahPreschool)



## Enrollment Checklist

2026-2027

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
- \_\_\_\_\_ Acknowledgements and Releases
- \_\_\_\_\_ 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](https://rmd.at/messiahp)

**The 2026-2027 school year operates from the second Monday in September through the Friday before Memorial Day in May. School hours are from 9:00 AM to 12:00 PM. 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 at Christmas and Easter. The school calendar will be provided the first week of school.

### **Meet the Teacher Morning – Friday, September 11, 2026**

Students and families are invited to come meet their teacher and see their classroom. A SignUp Genius link will be emailed the last week of August.





## Messiah Preschool Overview

2026-2027

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

## 2026-2027

Class requested: 2 yr. old – 2 day \_\_\_\_\_ (Age 2 by April 1<sup>st</sup>)      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 30<sup>th</sup> 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 (Name & 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 \_\_\_\_\_

-----  
STAFF USE ONLY

Identity Verification
Birth Certificate Number
Date Issued
** Staff Initial **

Registration
Date Received
\$   Staff Initial
Cash   Check #

New Registration
Quickbooks
Binder Copies
New File





## 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

2026-2027

Student Name \_\_\_\_\_

The Registration Fee and annual Tuition rates are as follows:

Registration Fee (cash or check only) ☐ \$175 (beginning March 1) ☐ \$150 Early Bird (until February 28)

### Select Preferred Class

<input type="checkbox"/> 2-year-olds	Tuesday and Thursday	Tuition - \$2430/yr or \$270/month
<input type="checkbox"/> 3-year-olds	Tuesday and Thursday	Tuition - \$2430/yr or \$270/month
<input type="checkbox"/> 3-year-olds	Monday-Wednesday-Friday	Tuition - \$2655/yr or \$295/month
<input type="checkbox"/> 3-year-olds	Monday through Friday	Tuition - \$3195/yr or \$355/month
<input type="checkbox"/> 4-year-olds	Monday-Wednesday-Friday	Tuition - \$2655/yr or \$295/month
<input type="checkbox"/> Pre-Kindergarten	Monday through Friday	Tuition - \$3105/yr or \$345/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 7th 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 at Christmas and Easter. If CPS closes for inclement weather, Messiah Preschool will also close. If CPS is delayed one hour, Messiah Preschool will open at 10:00 AM. 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: \_\_\_\_\_







# Acknowledgements and Releases

2026-2027

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.**

## 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 AMAT training. Only a provider who has successfully completed the AMAT 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:

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

Allergy and Anaphylaxis Medication Administrator(s) : AMAT 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 Policy & Mandated Reporting**

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.

## **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, telephone number and email address, as well as the name of parents, printed on a roster and distributed among the preschool class. \_\_\_\_\_ YES / \_\_\_\_\_ NO 

\*Please sign below acknowledging that you understand our policy regarding administration of medication and all other policies and releases stated above.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ 



**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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last First Middle Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Main Language Spoken: \_\_\_\_\_  
 Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 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: \_\_\_\_-\_\_\_\_-\_\_\_\_

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, dental appliance, 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 (6 <sup>th</sup> grade entry)	1				
*Polioyelitis (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 <60 months 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* (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.

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

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

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: ____ lbs. Height: ____ ft. ____ in. Body Mass Index (BMI): ____ BP ____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">1   2   3</td> <td style="width: 33%; text-align: center;">1   2   3</td> <td style="width: 33%; text-align: center;">1   2   3</td> </tr> <tr> <td>HEENT    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Neurological    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Skin    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Lungs    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Abdomen    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Genital    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Heart    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Extremities    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Urinary    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	1   2   3	1   2   3	1   2   3	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"/>	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"/>	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"/>
	1   2   3	1   2   3	1   2   3											
	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"/>											
	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"/>											
	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"/>											
TB Screening: <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"/> Positive <input type="checkbox"/> Negative CXR required if positive test for TB infection or TB symptoms.    CXR Date: ____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal														
EPSTD 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)					<b>Dental Screen</b>	<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
	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>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"/> epinephrine auto-injector <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</b> (Write legibly or stamp) <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).	
Name: _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ Fax: _____	Email: _____