



St. Anne's-Belfield School

TWO-YEAR-OLD'S PROGRAM
AUGUST BACK TO SCHOOL PACKET
2019 - 2020

St. Anne's-Belfield School

Dear Two's Program Families,

We are looking forward to the start of the 2019 - 2020 school year, which is fast approaching! Please review this packet closely as it contains lots of helpful information. But first, a few updates and reminders.

Faculty Changes

We are excited to welcome **Elizabeth Lane** to our Pre-School Building faculty. Elizabeth is a Charlottesville native who received her undergraduate degree from the University of Virginia (U.Va.) and her master's in teaching from the Curry School of Education also at U.Va. In addition to her role in the Pre-School, Elizabeth will serve as the director of the After School Enrichment Program (ASEP) for Grades K - 8. "My favorite thing about teaching Pre-School is the students' genuine love for being at school and learning. Engaging young children in learning a new skill, and seeing them carry that skill with them throughout their school career is why I love teaching Pre-School. Each teacher can make such an impact and I'm so grateful for the opportunity to do that. I can't wait to get started with the St. Anne's-Belfield community!" Elizabeth noted.

Additionally, we are excited to have **Ashley Buford** join the Pre-School as the Pre-School programs educational support assistant, taking over for Jill Mozee, who will be returning to her role in the Junior Kindergarten classroom. Ashley most recently worked as the academic secretary and registrar in the Grades 5 - 8 Office at our School and she is a former Pre-School teacher. Her desire to be back with the little ones is a bonus for our department. Ashley's family is a complete St. Anne's-Belfield operation as her husband Warren Buford serves as the associate head of School for advancement and their two sons, James and Max, are current students.

Partnership Meetings

We invite you to meet with your child's teacher before the start of the academic year. Partnership Meetings take place the mornings of Monday, Aug. 19 and Tuesday, Aug. 20. This meeting lays the foundation for a robust home-school partnership. You will receive an email with instructions about how to sign up for your meeting with your child's teacher. If you do not receive an email by Tuesday, Aug. 13, please contact the Pre-School Office at (434) 963-4858. In preparation for your Partnership Meeting, please complete the "Getting to Know Your Student" form in this packet. Your responses are important to us and we appreciate your input.

New Family Orientation & Returning Family Open House

You are invited to join us for the New Family Orientation & Returning Family Open House on Tuesday, Aug. 20. Both students and parents/guardians are invited, dress is casual, and dinner will be served. Please see the schedule below:

4:30 - 5:00 p.m. Families and students meet on the Pre-School Playground

5:00 - 5:30 p.m. Classroom visits

St. Anne's-Belfield School

First Days of School: Staggered Start

In order for the students to become familiar with their school setting, friends, and teachers in a small group situation, we will have a staggered start. There will be three different small groups of one hour each and your child will attend **one** of these staggered start times, either on Thursday, Aug. 22 or Friday, Aug. 23. Ms. Jen will assign your child to a session in an upcoming email. The staggered start sessions will be:

- Thursday, Aug. 22, 8:30 - 9:30 a.m.
- Thursday, Aug. 22, 10:00 - 11:00 a.m.
- Friday, Aug. 23, 8:30 - 9:30 a.m.

School will begin at the regular start time and with a full class on Monday, Aug. 26 for our 5-day and Monday-Wednesday-Friday students. Our Tuesday-Thursday class will begin at the regular time and with a full class on Tuesday, Aug. 27.

Convocation: Friday, Aug. 30

Convocation is a special St. Anne's-Belfield event that marks the opening of the academic year. Students in Grades 4 - 12 are required to attend and the senior class is recognized as they process in, accompanied by their parents. **The Pre-School Building will not be in session on this day.**

Pre-School Curriculum Night

Pre-School Curriculum Night will take place **Thursday, Sept. 19**. More details will follow in the Weekly Digest.

Student & Family Handbook

Please read through the [Student & Family Handbook](#) carefully.

We look forward to welcoming you soon!

Best,



Kathy Carpenter

Director of Pre-School Programs

St. Anne's-Belfield School

IMPORTANT REMINDERS

1. The state requires that we **MUST** have a **Commonwealth of Virginia School Entrance Health Form** on file for each student **BEFORE** they enter school. After the form is completed by your physician, **complete the parent portion of the form** and bring it to the Pre-School office by Tuesday, Aug. 20.

For further information on immunization requirements, please visit:

<http://www.vdh.virginia.gov/epidemiology/immunization/requirements.htm>

2. The state requires that we look at each student's original birth certificate or passport as "proof of identity." Bring the certificate to the Pre-School Office. We need to have this information within seven days of your student's entrance to school, or we are required by the Virginia Department of Social Services (VDSS) to notify the police.
3. The Pre-School administration and faculty are only permitted to administer emergency medications such as EpiPens or inhalers due to VDSS standards. VDSS requires that paperwork from the doctor must be updated every six months. If your student needs emergency medication, please fill out this **Emergency Medication Authorization** and return it to the Pre-School Office.
4. All children must have a **Child Registration Form** on file by Aug. 20.

Tips for Completing the Child Registration Form

- Please be sure to fill out every section, leave no blanks.
 - If a specific box does not apply, mark "N/A" in the box.
 - If the registration form is not completed, your student(s) cannot attend St. Anne's-Belfield School or the After School Enrichment Program (ASEP).
- Please complete a registration form for EACH student. References cannot be made from one registration form to another.
- Consider writing a **cell phone** instead of a **home phone** if that number is the best number to reach you after school.
- In the section entitled "Two People to Contact if Parent(s) Cannot Be Reached," list the names of two people who live in Charlottesville or the surrounding area (not more than one hour away), complete with physical (street) addresses (no P.O. Boxes) and phone numbers. Listing persons who live out of the area is not practical because their help cannot be enlisted in an emergency.

St. Anne's-Belfield School

CLASS LISTS

Student homeroom assignments are located on the [Veracross Parent Portal](#).

St. Anne's-Belfield School

GENERAL INFORMATION

Regular School Hours: Monday - Friday: 8:30 – 11:30 a.m.

You must check with the director of Pre-School programs if you would like your student to arrive prior to 8:30 a.m. The 8:15 a.m. option is available only to families with older siblings at the School.

Dress Code

Pre-School students are **not** required to adhere to the St. Anne's-Belfield School uniform dress code. We do ask that students not wear shirts displaying emblems such as Star Wars or other cartoon characters. In addition, Crocs™ shoes and slip-on shoes are not allowed due to safety concerns. All shoes should have closed toes.

School Items

Please make sure to label all items of clothing. You will need to keep two changes of clothing in the Pre-School building, and please change the clothing as the seasons change. Diapers, pull-ups, and wipes will be stored individually for each student and can be brought to the Partnership Meetings.

Arrival & Dismissal

You must walk your two-year-old into the building at drop off and walk in to pick up your student at the 11:30 a.m. dismissal. Please park your car in the parking lot next to the school and not on the road in front of the Pre-School Building.

Kinderlime

We use Kinderlime to streamline our check-in and out processes. Each parent or authorized pickup will have a four-digit pin which they will use to drop off or pick up their child. The pins will be automatically emailed to each authorized parent prior to school starting. With this pin, you will be able to sign your child in and out quickly and more securely via the kiosk setup at the entrance of the Pre-School. **Please make sure that you have your pin prior to the first day of school.** To assign a pin to (an) additional person(s) for authorized pickup, please login to your Kinderlime account prior to school starting.

Snacks & Parties

Snacks are provided by the School. All special treats will be provided by the School due to concerns about allergies.

Attendance, Absences, & Tardiness

Students who are not in their classrooms by 8:45 a.m. are marked absent. The Pre-School programs educational support assistant will call you after 9:00 a.m. if the reason for your student's absence is unknown. This practice is for your student's safety.

If your student is not attending school on any given day due to illness or an emergency situation, please make sure to inform the Pre-School Office. If a student will be late, please call or email as soon as possible. You can either call the direct line to the Pre-School Building (434) 963-4858 or email abuford@stab.org or kcarpenter@stab.org.

St. Anne's-Belfield School

PARENTS' ASSOCIATION

Dear St. Anne's-Belfield School Parents,

We need you! This school year, I challenge each of us to find time to volunteer. There are so many opportunities to help out before, during and after school, all with the added bonus of meeting other parents in our school community. Plus, it's a fun way for us to see and fully appreciate all the experiences our children have at St. Anne's-Belfield! There are so many great ways you can help out this year: concession stand sales for sports and theater events, Grandparents' & Special Friends' Day, Maroon & White Party silent auction asks, Arts Boosters and Athletics Boosters, becoming a host family for a boarding student, or assisting with the Parents' Association's (PA) largest fundraiser – Saints' Closet, our uniform resale shop. Nothing jumping out at you? There's plenty more! Just email me what you are interested in and I can help you find the perfect thing. Whether you are new to St. Anne's-Belfield School or have been here for 12 years, there's plenty to do so please consider getting involved.

I want to get a few PA items on your calendar and let you know about some upcoming events. Our very own, **Saints' Closet** will be hosting the back to school uniform consignment sale on Aug. 19 & 20 in the Conway Convocation Center (799 Faulconer Dr.), so go stock up on your Land's End uniforms and School gear. There are still some volunteer opportunities available for this, please contact [Gena Greer](#) if you are interested in working a shift or have any questions. There will be more consignment sales as the year goes on, we'll make sure to keep you posted on these.

Starting in October we will be having **Faculty Appreciation Lunches** to celebrate our teachers and how much they do for our children. We will call on parents to contribute to a themed potluck lunch item or refreshment and will do this throughout the year.

The Division Coordinators will each be hosting back to school get togethers so you can get to know your grade level reps, PA representatives and the division heads. You will be receiving more information as the events get closer. Here are the dates:

- **Pre-School Building "Pick-Me-Up with Kathy Carpenter" on Sept. 5 from 11:00 - 11:45 a.m.**
- **Grades K - 4 "Afternoon Pick Me Up at Pick Up" will be on Sept. 4 from 2:30 - 3:15 p.m.**
- **Grades 5 - 8 "Afternoon Pick Me up at Pick Up" will be on Sept. 3 from 2:45 - 3:30 p.m.**
- **Grades 9 - 12 "Coffee and Conversation" will be on Sept. 3 at 8:45 - 9:30 a.m.**

Shannon Montague and Peter Quagliaroli will also be hosting division specific **Parent Chats** throughout the year. These chats give parents a chance to hear what's going on in the community as well as the opportunity to hear expert speakers and discuss relevant topics.

We will have an all-School meeting in mid-October where we will hear from the **Athletics Task Force**. They are eager to reconnect with parents about the work they have been doing and discuss their proposed goals and policies. Be looking for date and time information in your inbox sometime in the next few weeks.

St. Anne's-Belfield School

Now for three of the most popular events of the year – **Fall Family Picnic** is hosted by the Athletics Boosters and will be on Friday, Oct. 18. There will be music, BBQ, kids' activities, and most importantly, our awesome student-athletes will be playing games all over campus, so come support St. Anne's-Belfield and have fun at this all-School community event. I know January seems far away, but the Arts Boosters will be hosting the **Annual Fine Arts Concert & Wearable Art Runway Show** on Friday, Jan. 24 with a matinee Runway Show on Saturday, Jan. 25. This event always sells out fast, so get it on your calendar and be on the lookout for ticket information. The **Maroon & White Party** on May 2, 2020 is our adults-only community event and fundraiser. It's a great night to mingle, dance, eat, and bid on some fun items with your friends, teachers, and administrators. This year we will also take a moment to say goodbye to Head of School David Lourie and look back at his time here at St. Anne's-Belfield School. You will be getting a much more official save the date and invitation in the coming months, but please mark it on your calendars now.

Be sure to check your email for information about all of these events and more from your Grade Level Reps and Division Coordinators and be sure to read your Weekly Digests. The Digests are filled with information and will keep you in the loop.

If you have any questions or concerns please feel free to [email me](#) anytime. I hope to see you all at Convocation on Friday, Aug. 30, and thank you for supporting the St. Anne's-Belfield community. Here's wishing you all a wonderful 2019 - 2020 school year!

All the best,

Sterling Frank

Parents' Association President, mom to Isabella '21

St. Anne's-Belfield School

PRE-SCHOOL AUTHORIZATION TO GIVE MEDICATION FORM

- Due to standards set by the Virginia Department of Social Services, our faculty in the Pre-School programs may only administer *emergency medications* such as inhalers or Epi-Pens.
- The permission slip below must be filled in for any type of medication.
- If a medication needs to be given for a length over ten working days, the permission form must be signed by your child's physician.
- All medications must be labeled with the child's name, the name of the medications, the dosage amount and when it is to be taken.
- All medications, both prescription and non-prescription, must be in the *original* container and the date on the prescription must not be expired.

Child's Name: _____ Date of Birth: _____

My child has these known allergies: _____

St. Anne's-Belfield has my permission to administer the following medicine:

Medicine Name: _____

Dosage and Times to be Given: _____

Reason for Giving This Medicine: _____

Possible Side Effects: _____

Special Instructions (If Any): _____

This authorization is effective from: _____ to _____

Parent's or Guardian's Signature: _____ Date: _____

St. Anne's-Belfield School

My action plan for emergency medication is:

1. My child will show the following symptoms when emergency medications are needed:

a. _____

b. _____

2. When demonstrating these symptoms, I authorize St. Anne's-Belfield School to provide the medications as specified below.

3. I would like to be contacted each time an emergency medication is administered.

Yes _____ Not Necessary _____

4. I understand that medicines logs will be on file so that parents can follow the delivery of these medications if necessary.

If any medicine (prescription or non-prescription) is administered longer than 10 work days, we must receive written authorization from the child's physician and parent or guardian.

I certify that in my opinion, it is medically necessary that the medicine described below be administered to:

Child's Name: _____

Date of Birth: _____

Medicine Name: _____

Dosage and Times to be Given: _____

Duration: _____

Possible Side Effects: _____

Special Instructions: _____

Physician's Signature: _____

Name of Physician: _____ Phone: _____

St. Anne's-Belfield School

PARENT AUTHORIZATION FOR ADMINISTERING SUNSCREEN

Please submit this form to the School administration as needed. All areas on the form must be completed for the School to administer sunscreen. Please print clearly.

Please have a member of the faculty administer sunscreen to the following:

Child Name: _____

I understand that the person at the School who will administer this sunscreen may be inexperienced and untrained in this requested service and state, without reservations, that I shall not hold them or St. Anne's-Belfield School liable in any way for harm or injury that may be experienced by my child as a result of this service. I also understand I am to provide all sunscreen administered to my child in its original container.

Date: _____

Brand of Sunscreen & SPF: _____

Exact Dosage to be Given: _____

Time of Day to be Applied: _____

Duration of Application: _____

Special Instructions/list all adverse reactions: _____

****WE DO NOT APPLY INSECT REPELLENT ON ANY CHILD. IF NECESSARY, ALL INSECT REPELLENT MUST BE APPLIED BEFORE THE CHILD ARRIVES AT THE SCHOOL.**

** According to state requirements, children nine years of age and older may administer their own sunscreen if supervised.

I hereby give my permission to St. Anne's-Belfield School faculty members to administer the above-referenced sunscreen to my child.

Signature: _____ 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 | | | | |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------|---|------------------------------------------------------------------------------|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| *Diphtheria, Tetanus, Pertussis (DTP, DTaP) | | | | | |
| *Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | | | | | |
| *Tdap booster (6 th grade entry) | | | | | |
| *Poliomyelitis (IPV, OPV) | | | | | |
| *Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age | | | | | |
| *Pneumococcal (PCV conjugate) *only for children <60 months of age | | | | | |
| Measles, Mumps, Rubella (MMR vaccine) | | | | | |
| *Measles (Rubeola) | | | Serological Confirmation of Measles Immunity: | | |
| *Rubella | | | Serological Confirmation of Rubella Immunity: | | |
| *Mumps | | | | | |
| *Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used | | | | | |
| *Varicella Vaccine | | | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | |
| Hepatitis A Vaccine | | | | | |
| Meningococcal Vaccine | | | | | |
| Human Papillomavirus Vaccine | | | | | |
| Other | | | | | |
| Other | | | | | |

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.

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Health Assessment | Date of Assessment: ____/____/____ Weight: _____lbs. Height: _____ft. ____in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided | Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><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 _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------|------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hearing Screen | <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 | | | | | |

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------|-----|-------------------------------------|------------|
| Vision Screen | <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 | Test used: |
| | | 20/ | 20/ | 20/ | |
| <input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen | | | | | |

| | |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dental Screen | <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 |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Recommendations to (Pre) School, Child Care, or Early Intervention Personnel | Summary of Findings (check one): <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: _____ | |

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------|
| Health Care Professional's Certification (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: _____ |

**DIVISION OF LICENSING PROGRAMS
DEPARTMENT OF SOCIAL SERVICES
CHILD REGISTRATION FORM (Model)**

| | | | |
|---------------------------------------------------------------------------------------------|----------|---------------|------------|
| Child | Nickname | Date of Birth | Sex |
| Address | | | Home Phone |
| Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed | | | |
| Previous Child Day Care Programs and Schools Attended | | | |
| If Child Attends this Center and Another School/Program, Give Name of School/Program | | | Grade |

PARENT(S)/GUARDIAN(S)

| | | |
|---------------------------------------------------|----------------|----------------|
| Father | Place Employed | Business Phone |
| Home Address | | Home Phone |
| Mother | Place Employed | Business Phone |
| Home Address | | Home Phone |
| Person(s) or Agency Having Legal Custody of Child | | |
| Home Address | | Home Phone |
| Business Address | | Business Phone |

EMERGENCY INFORMATION

| | | |
|----------------------------------------------------------------------------------------|---------|-------|
| Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency | | |
| Child's Physician | | Phone |
| Two People To Contact if Parent(s) Cannot Be Reached | Address | Phone |
| 1. | 1. | 1. |
| 2. | 2. | 2. |
| Person(s) Authorized To Pick Up Child | | |
| Person(s) <u>NOT</u> Authorized To Pick Up Child* | | |

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day care activities.

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

| | |
|-----------------------------------------------------------------------------------|---------------|
| <i>Parent(s) or Guardian(s)</i> | <i>Date</i> |
|  | Aug. 26, 2019 |
| <i>Administrator of Center</i> | <i>Date</i> |

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.