ReachFar Foundation

Child Registration Form

SECTION I. GENERAL INFORMATION

CHILD	NICKNAME (if applicable)	SEX	AGE	DATE OF BIRTH
HOME 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
OTHER SIBLING ENROLLED IN PROGRAM (use back of form if needed)	AGE
1.	
2.	

SECTION II. PARENT(S) GUARDIAN(S)

FATHER	PLACE EMPLOYED		EMAIL	BUSINESS PHONE
HOME ADDRESS (if different than child)			CELL PHONE	HOME PHONE
MOTHER		PLACE EMPLOYED	EMAIL	BUSINESS PHONE
HOME ADDRESS (if different than child)			CELL PHONE	HOME PHONE

SECTION III. EMERGENCY INFORMATION

ALLERGIES OR INTOLERANCE TO FOOD, MEDICATION, ETC., AND ACTION TO TAKE IN AN EMERGENCY			
DOES YOUR CHILD HAVE PERMISSION TO HAVE SUNSCREEN APPLIED? (circle one)			YES NO
DOES YOUR CHILD HAVE PERMISSION TO HAVE INSECT REPELLENT APPLIED? (circle one)			YES NO
CHILD'S PHYSICIAN			PHONE
TWO PEOPLE TO CONTACT IF PARENT(S) CANNOT BE REACHED	ADDRESS		PHONE
1.	1.		1.
2.	2.		2.
MEDICAL INSURANCE PROVIDER		POLICY #	PHONE
PERSON(S) AUTHORIZED TO PICK UP CHILD			
PERSON(S) NOT AUTHORIZED TO PICK UP CHILD			

NOTE: 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.

Parent(s) Guardian(s) Initials: _________________

ReachFar Foundation

Child Registration Form

PHILOSOPHY

The philosophy of the ReachFar Child Development Center is that we believe each child is a unique and special individual who has the right to safe, stimulating, and educational child care regardless of race, gender, color, religion, economic background or culture. We know how hard it is to leave your child in the care of another but rest assured that your child will be cherished and kept safe while you are away.

In order to help children grow to their fullest potential, we believe children should be provided with materials, instruction and activities which meet their developmental needs. the responsibilities of our program include making sure the children are safe, assisting them when they need help, providing appropriate toys and activities, maintaining a flexible but predictable routine day, and providing them with gentle positive discipline and guidance.

It is important that children learn to become self-disciplined. A child armed with self-discipline has a tremendous asset for addressing life's challenges. Children learn self-discipline through consequences and choices. By teaching children to become self-disciplined we are helping them develop a quality that will enable them to be successful in life.

GOAL

Our goal is to provide high quality child care by creating a safe, healthy, and caring environment that promotes the physical, social, emotional, cultural, and cognitive development of your child, as well as responding to the needs of your family. We partner with parents; working together to help our children grow happy, healthy, and strong, and building a relationship of mutual trust and respect.

STATEMENT OF ACCOUNTABILITY

I, ______________________ understand that day care/camp may have certain inherent risks, that the environment is different from home, and that situations may arise that will be dealt with differently than in my home. I understand that reasonable discipline may be needed and exercised in accordance with day care/camp policy. I acknowledge receipt of and approval of the discipline policy.

I, ______________________ agree that my child will act in a responsible way, respecting other people, as well as the day care/camp property and facilities. I understand that he/she may be terminated from day care/camp if he/she behaves in a negative or threatening way toward others, damage or destroy day care/camp property, or fail to obey rules.

I give my permission for any photos taken at camp to be used for the promotion of camp.

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.

I have read and understand the camps statement of accountability and conduct and dress rules.
By signing this agreement I will abide by the camp rules. Failure to do so will result in dismissal from camp. Tuition is non-refundable.

SIGNATURES

____ ____________________

Parent(s) or Guardian(s) Date

____ ____________________

Administrator of Center Date

Date Child Entered Care: ____________________ Date Left Care: ____________________

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

ReachFar Foundation

Child Registration Form

OFFICE USE ONLY
IDENTITY VERIFICATION

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

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

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

____
Date

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

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

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

Part I – HEALTH INFORMATION FORM

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

Name of School: ______________________________ Current Grade: ______________________

Student's Name: ____
Last First Middle

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

Student's Address: ______________________________ City: ____________________ State: _______________ Zip: _______________

Name of Mother or Legal Guardian: ______________________________ Phone: ______-______-________ Work or Cell: _____-_____-______

Name of Father or Legal Guardian: ______________________________ Phone: ______-______-________ Work or Cell: _____-_____-______

Emergency Contact: ______________________________ Phone: ______-______-________ Work or Cell: _____-_____-______

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

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

____

____

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

____

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

Please provide the following information:

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

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

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

Signature of Parent or Legal Guardian: ______________________________Date: _______/________/ __________

Signature of person completing this form: ______________________________Date:_______/________/___________

Signature of Interpreter: ______________________________Date: ______/______/_________

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.)

Certification of Immunization 10/2010

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:** ____

REPORT OF TUBERCULOSIS SCREENING
CHILDREN'S PROGRAMS

Standards and child care policy require certain individuals to submit a report indicating the absence of tuberculosis in a communicable form when involved with (i) children's facilities regulated by the Department of Social Services or (ii) legally operating child care programs, excluding care by relatives, that receive Child Care and Development Funds. Each report must be dated and signed by the examining physician, the physician's designee, or an official of a local health department. When signed by the physician's designee, the form must also identify the physician/physician practice with which the physician –designated screener is affiliated.

Name: ____ **Date of Birth**: _________________________

Address (Street, City, State, Zip Code): ____

____

1). ____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

---

2). Tuberculin Skin Test (PPD): Date given: __________ Date read: _________

Results: _______ mm Positive: ________ Negative: ________

---

3). ____ The individual has a history of a positive tuberculin skin test (latent infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

---

4). ____ The individual either is currently receiving or has completed medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

---

5). ____ The individual had a chest x-ray on ___________ (date) at ______________________________ (location) that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: ____ Date: ___________
(MD/designee or Health Department Official)

____
(Print Name/Title)

Address (including name of practice, if appropriate):

____
____
____
____

Telephone number: ____

MAT

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered:____________________

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) ____________________

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: Additional side effects:____________________

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe):____________________

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) ____________________

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):

16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

Required for Long-Term medication or when dosage directions state "consult a physician".

This is a double-sided form

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No
Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):____________

20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to ________________________________.
(child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:

23. Parent or legal guardian's signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility telephone number:	26. (leave blank)

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.

28. Authorized child care provider's name (please print):	29. Date received from parent:

30. Authorized child care provider's signature:

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on ________________________ . Once the medication has been discontinued, I understand that if my child
(date)
requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. ____

34. Licensed Authorized Prescriber's Signature:

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.
DATE:____________________
By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:

ReachFar Foundation

Field Trip Permission Slip

This Section to be Completed by Staff		
Child:	Day Care/Camp: Reach Far Youth Development Ctr	Age:
Field Trip (Include Purpose and Planned Activities, if needed):		
Date(s) of Trip:	Time(s) of Trip:	Expense (if any):
Mode of Transportation (check all that apply): ☐ Private Vehicle ☐ Walking ☐ School Bus ☐ Charter Bus ☐ Public Transportation ☐ Commercial ☐ Air		
Vehicles driven by: ☐ APS Bus Driver ☐ Staff ☐ Parents ☐ Other Adult		
Related risks (check all that apply) ☐ Swimming Pool ☐ Amusement or Theme Park ☐ Beach, River, Stream, or Ocean ☐ Walking to Destination		

Parents/Guardians – Please Read the Following, Check the Appropriate Boxes, and Sign this Section

Parent/Guardian Authorization and Acknowledgement of Risk

I, as the parent or legal guardian, give permission for child named above to participate in this field trip. I understand that participation in this field trip is voluntary and not a required part of the school curriculum. I understand that it exposes my child to some risk. I have read and understand the purpose of the field trip and authorize my child to participate in above referenced field trip and to be transported as noted above. I also understand that participation in the field trip will involve activities outside of the ReachFar Youth Development Center; therefore, neither ReachFar Youth Development Center staff nor volunteers, will have any responsibility for the condition or use of any outside property. I expressly agree to hold harmless and reimburse the ReachFar Foundation, its individual members, agents, staff and representatives, as well as trip supervisors and chaperones, for any and all losses, damages or injuries arising out of, in connection with, or during the above named student's participation in this trip, to include but not limited to any costs incurred for the rendering of any emergency medical procedures or treatment, if any.

☐ I agree to the above ☐ I opt out of this field trip

NOTE: Children who **DO NOT** have permission to participate in this field trip will need to remain at home on the day of the trip. Parents will be given notice one-week in advance to make other arrangements. Tuition will **NOT** be discounted or refunded for day(s) child is not in attendance.

Notice of Financial Responsibility

Please note that the ReachFar Youth Development Center reserves the right to cancel any trip for safety or other reasons. In the event of such a cancellation, the trip cancellation policies, as well as those of the hotels, bus companies, ticket operators and others providing services in connection with the trip will determine the amount of any refund to which you are entitled, if any. Refunds or any other reimbursements will not be provided by the ReachFar Youth Development Center if the trip is cancelled or delayed by the vendor, but instead will rescheduled. By signing below, parents and guardians acknowledge that they have read this notice and accept responsibility for any and all cancellation fees, costs, losses, medical expenses, hospital or physician fees, or any other expenses incurred by or on behalf of the parent, guardian, or their students related to this trip.

☐ I agree to the above

Medical Authorization

The ReachFar Youth Development Center has my permission, when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital (in a private automobile or emergency vehicle). I further provide the hospital and its medical staff my authorization to provide treatment which a physician deems necessary for the well-being of my child. **The following information is accurate to the best of my knowledge.**

ReachFar Foundation
Field Trip Permission Slip

☐ I agree to the above	
Parent/Guardian (Or Eligible Student Over Age 18) Signature:	Date:

Child Agreement

While participating on this school-sponsored field trip, I will accept responsibility for maintaining good conduct and behavior. I will follow directions at all times. I am subject to the *child code of conduct* as outlined in the ReachFar Youth Development Handbook.

Child Signature:	Date:

EMERGENCY CONTACT INFORMATION

Contact Information During the Time Period of the Field Trip

Mother or Guardian Name:		
Home Phone:	Work Phone:	Cell Phone:
Father or Guardian Name:		
Home Phone:	Work Phone:	Cell Phone:
Alternate Contact Name:		Relationship:
Home Phone:	Work Phone:	Cell Phone:
Medical Care Information		
Family Physician:		
Health Insurance Company:		
Group Policy Number:		
ID Number:		
Phone Number:		
Student allergic to any medications? If so, please list:		
Any other allergies (food, bee stings, etc.)? If so, please list:		
Medication during trip (see note below):		
Describe any special needs of the above student related to this trip:		

NOTE: Medications for field trips that occur during the day, and for which there is a medication and authorization form on file, will accompany the child during field trip and be administered by an MAT certified staff member. It is the responsibility of the parent to provide authorization and medications to staff for trips outside the regular day and/or lasting more than one day.

SWIMMING/WADING ASSESSMENT AND PERMISSION

Dear Parent/Guardian,

We are very excited to have your child, ____, enrolled at the ReachFar Youth Development Center. Under supervision of staff members, students may be wading or swimming in a water depth of less than two feet as they explore the outdoors on their field trips. The Virginia Department of Social Services mandates that a parent/guardian provide us with a statement advising us of a child's swimming skills and provide written permission for a child to participate in swimming or wading activities. Please complete the information below and submit this form before or on the first day of enrollment.

Swimming/Wading Assessment

Please indicate your child's swimming level and capabilities (circle one):

Non-Swimmer Beginner Intermediate Advanced

Please indicate below if there is anything we should be aware of regarding your child's swimming capabilities and needs.

Permission

I, ___________________________________, **GIVE my child**, ___________________________________, permission to participate in wading and swimming activities.

I, ___________________________________, **DO NOT give my child**, ___________________________________, permission to participate in wading and swimming activities. NOTE: Children who DO NOT have permission to participate in swimming activities will need to remain at home on days swimming is scheduled. Parents will be given notice one-week in advance to make other arrangements. Tuition will NOT be discounted or refunded for day(s) child is not in attendance.

Parent/Guardian Signature: ____ Date: ______________

Swimming & Wading Rules and Protocol

- All swimming and wading rules will be explained to children before going into the water.
- Swimming/wading will only take place during daylight hours.
- Children are allowed to be in no more than two feet of water unless there is a certified lifeguard on duty.
- Children must always swim/wade with a buddy.
- NO running, jumping or diving is not permitted.
- Bottles, glass, and sharp objects are not allowed in the swimming area.
- An emergency telephone and first aid kit will be present at all times.
- A head count will be done before leaving center, when arriving at destination, and before returning to center.