Providence Nursery School

A Co-operative Preschool

Dear 2s Class Parents:

As you can imagine – or remember, for returning parents – there are several forms that must be completed and on file at PNS before your child can start school in the fall. Without a doubt, completing these forms is the least enjoyable aspect of the school year, but many are required by the State of Virginia, and all are important in promoting your child's safety and well-being.

All of your required forms will be available via email and on the PNS website prior to the Spring Coffee meeting on May 2nd.

Please read the forms carefully, fill them out promptly, and make sure to sign where applicable. If you'd like to complete and submit all of them to me at the Spring Coffee, that would be great and give you less to worry about! If not, they must be returned to PNS, or to my home address below, by June 1, 2011. Families who return forms after that date will be charged a late fee of $25. After July 1, 2011, the fee is $35.

Here is a brief overview of the forms required for the 2s class:

- **Membership Responsibility Contract** (Form 1) – specifies parental responsibilities at Providence Nursery School, which you agree to fulfill upon signing. One must be filled out for each class in which you have a child and be signed by both parents;
- **Child Development** (Form 2) – provides important information about your child for his/her teacher;
- **Parent Resources** (Form 3) – identifies parent resources for teachers and board members;
- **Family Job Preference** (Form 4) – identifies which family jobs interest you. Families who buy-out must also choose a job. You do not have to fill out this form if you already have a family job for next year;
- **Co-oping and Substituting** (Form 5) – provides co-op and substituting information for the class representative. Not required for buy-out families;
- **Parent Health** (Form 6) – required of all adults helping/working on a regular basis in state-licensed schools. Requires a physician's signature/official stamp. Good for a two-year period – *You will be notified separately if you are due to have this redone*. Not required for buy-out families;
- **Sworn Statement or Affirmation** (Form 9) – required by all adults co-oping in the classroom. This form solicits information about convictions and child abuse complaints inside and outside of Virginia. This statement must be collected every year;
- **Emergency Care and Contact** (Form 10) – includes permission to seek emergency medical care at school, lists emergency contacts and persons allowed to pick up your child from school, and dietary restrictions. Please make sure both parents sign this form;
- **Proof of Identity** – the state of VA requires proof of child's identity and the names of current and prior child care facilities or preschools your child has attended. *This form is good for the entire time your child is enrolled at PNS*;
- **VA School Entrance Health Form** – to be filled out by you and your child's doctor. Your child may not attend class until we have the completed form with a physician's signature. *This form is good for the entire time your child is enrolled at PNS*;
- **Virginia DSS Central Registry** – this form is required of all adults co-oping in the classroom and is good for a three-year period – **this form must be notarized**. For your information, we are also required to conduct a criminal history and sex offender name search with the Virginia State Police**.** We use the information you provide on your DSS form to conduct that background check using the Virginia State Police website. PNS pays for both services, and we mail the forms in ourselves. *You will be notified separately if you are due to have this redone*.

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If your child has a life-threatening health condition that requires medication to be kept at school – such as a food allergy requiring an Epipen – let me know. There is separate form for that.

I've included a checklist below to help you keep track of your forms so that nothing is left incomplete. Please contact me with any questions you may have as you go through this information. Also, if you run into problems completing your forms as the due date draws near, please let me know.

Thank you!

Angie VonAncken,
Vice President of Membership/Forms
10925 Roma Street
Fairfax VA 22030
703.934.4097
avonancken@gmail.com

Required Family Forms Checklist – 2s Class

_____ Membership Responsibility Contract (Form 1) – *one per child/class*
_____ Child Development (Form 2) – *one per child*
_____ Parent Resources (Form 3) – *one per family*
_____ Family Job Preference (Form 4) – *one per family*
_____ Co-oping and Substituting (Form 5) – *one per family*
_____ Parent Health (Form 6) – *one per co-oping parent*
_____ Sworn Statement or Affirmation Form (Form 9) – *one per co-oping parent*
_____ Emergency Care and Contact (Form 10) – *one per child*
_____ Proof of Identity – *one per child (returning families do not have to complete)*
_____ VA School Entrance Health Form – *one per child (returning families do not have to complete)*
_____ Virginia DSS Central Registry Search – *one per co-oping parent*

Providence Nursery School

A Co-operative Preschool

(FORM 1)

Member Responsibilities Contract – 2s Families

Providence Nursery School is a cooperative preschool that relies on the involvement of parents to make our school a success. When every family gets involved, both our school and our children benefit.

Every Providence family with a student in the 2s class is required to do ALL of the following for the 2011-2012 school year, with a few exceptions (see below):

1) Co-op in the classroom as assigned or find a replacement (not required if you are a buy-out family)*
2) Perform your assigned family job (discussed in attachments)
3) Participate in a PNS Clean-Up/Maintenance Day once per year*
4) Volunteer eight (8) hours of time to the school
5) Participate in at least two (2) fundraisers – one in the fall and one in the spring – but preferably more
6) At least one (1) parent will attend the Spring Coffee (May 2, 2011), Back to School Night (September 7, 2011), and General Membership Meeting (March 12, 2012)
7) Turn in appropriate forms and paperwork by June 1, 2011, all forms become the property of PNS and will not be copied or returned to a family for any reason
8) Pay security deposit of one month's tuition and half of the materials fee by June 1, 2011*, deposits are non-refundable after July 1st
9) Meet the minimum required Parent Education hours (four (4) per co-oping parent)

***These items are done for each class in which you have a child enrolled.**

****** You are only allowed one buy-out per year per child enrolled.**
You may choose from co-oping, clean-up/maintenance day, volunteer hours or fundraising.

While attendance at Board Meetings is not mandatory, it goes a long way towards strengthening your family's and children's valuable relationship with the school.

I understand that my fulfillment of the Member Responsibilities listed above will be reviewed at the January 2012 board meeting. I also understand that should I fail to make a reasonable effort towards completing these responsibilities, my family's standing at PNS may be negatively impacted, including my eligibility to enroll my child(ren) for the following school year, as well as my eligibility to return for the remainder of the 2011-2012 school year. By signing this contract, I agree to these conditions.

Parent Signature:_____ Date: _____

Parent Signature:_____ Date: _____

President: *Marta Davis and Kelly Volciak* Date: *May 2, 2011*

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Providence Nursery School

A Co-operative Preschool

(FORM 2)

Child Development

Child's Name: _____ **Sex:** F M
First Middle Last

Class: CDO 2s 3s 3/4s 4s Summer Program

Name child likes to be called: _____ **Birth date:** _____

Parents' Names: _____ **Telephone:** _____

Address: _____
Street City Zip Code

Directions from the school to your home: _____

_____

_____

_____

Food Habits: Does your child have any food allergies or restrictions? _____

_____

Language: Any speech difficulties? Are there any other languages spoken at home? _____

_____

Health: Is your child under medical care or taking any medication for a continuing illness? _____

_____

Family: Other children in family (names, ages)? Other adults currently living in the home? _____

_____

_____

Do both parents live with child? (If no, please explain briefly)_____

_____

Home and social experiences:
Does your child have any known fears? _____

Any Pets? _____ Religious Preference? _____

Other group experiences?_____

Toilet Training: Where is your child in the process? _____

_____

**All information provided will be kept confidential between you and your child's teacher*

Providence Nursery School

A Co-operative Preschool

(FORM 3)

Parent Resources

Parents' Names: _____
Mother **Father**

Child(ren)'s Name(s): _____

Class(es): CDO 2s 3s 3/4s 4s

Mother's profession: _____

Father's profession: _____

Do you have any special skills or talents that you would like to share with your child's class? (i.e., hobbies, musical, artistic or dramatic training, knowledge of a foreign country or language, etc.)

Would you be willing to discuss your profession with your child's class or other Providence classes?

Do you have any personal or business relationships that might be helpful in arranging field trips or enrichment activities? If so, please detail.

Do you have any personal or business relationships that might be helpful in purchasing discounts or donations of art and school supplies, equipment, etc.? If so, please detail.

Do you know of any individuals, or local or national businesses that would be willing to donate an item, service, or gift certificate for our fall raffle?

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Providence Nursery School

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(FORM 4)

Family Job Preference

Parent Name(s): _____

Name(s) of Child(ren): _____

Class(es) (please circle each class in which you have a child enrolled):

2s 3s 3/4s 4s

Phone Number: _____

Please list your Family Job preferences and briefly say why you are interested in the job. Please see "Family Jobs" on our website, www.providencenurseryschool.com for more information on family jobs. You can also contact the VP of Administration, Ryan Bianchetti, at rdbianchetti@gmail.com or 703-425-4426 with questions.

1st Choice

Job Title: _____

Reason for Choosing: _____

2nd Choice

Job Title: _____

Reason for Choosing: _____

3rd Choice

Job Title: _____

Reason for Choosing: _____

Do you have any special considerations? (e.g. Do you work part-time or full-time; would you prefer a job that can be done at home in the evenings? On weekends? During school hours? With a younger child?) We can't guarantee that we can accommodate everyone's needs but we will try our best. Any information that you provide will be kept confidential between you and the VP of Administration.

_____

_____

_____

_____

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Providence Nursery School

A Co-operative Preschool

(FORM 5)

Co-oping and Substituting

Please fill out BOTH sections of this form. Thank you!

Section One: Co-oping Preferences

Child's Name: _____

Class: 2s 3s 3/4s 4s

Will you be co-oping for more than one child at PNS? _____

If so, what are the other child(ren)'s class(es):2s 3s 3/4s 4s

Co-oping Parent's Name(s): _____

Phone Number: _____ Email address: _____

Are there any day(s) of the week you cannot co-op? _____

_____

Are there any specific dates you cannot co-op September through December? _____

_____

Are there any specific dates you cannot co-op January through June? _____

_____

Section Two: Substitute Availability

From time to time, PNS is in need of parents who can assist in the classroom (classes vary) as a last-minute substitute. Subbing works best if you have no younger children at home, no on-going work commitments and/or a flexible schedule during the day.

Are you available to substitute? _____

If yes, on what days?_____

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Providence Nursery School

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(FORM 6)

Parent Health

Child(ren)'s Name(s): _____

Class(es): 2s 3s 3/4s 4s

The Fairfax County Code requires any parent who will be participating in a preschool classroom to be screened every two years for risk and symptoms of Tuberculosis infection and disease. If screening shows you to be at risk of having been exposed to TB, you must obtain a tuberculin test or chest X-ray. While we cannot *require* that you have the full test (instead of just screening), we highly recommend it.

These services can be obtained from your doctor or your local health department (Joseph Willard Health Center, 3750 Old Lee Highway, Fairfax, VA, phone: 703.246.7100).

Please attach evidence of a satisfactory risk screening, PPD test or chest X-ray result, signed or stamped by attending medical personnel.

Mother's full name: _____ Date: _____

Screening or test result: _____

_____

Father's full name: _____ Date: _____

Screening or test result: _____

_____

Please indicate if there are any health considerations that may interfere with fulfilling your cooperative responsibilities. As always, consult with your physician before testing if you are, or think you may be pregnant.

_____

_____

_____

_____

_____

4/10

Providence Nursery School

A Co-operative Preschool

(FORM 9)

Sworn Statement or Affirmation

Please Print

Last Name	First	Middle	Maiden	Social Security Number

Current Mailing Address	City	Zip Code

Name of Licensed/Registered Approved Facility/Provider	City	Zip Code
Providence Nursery School	**Fairfax**	**22031**

1. Have you ever been convicted of or are you the subject of pending charges of any crime **within** the Commonwealth **or** equivalent offense **outside** the Commonwealth?

Yes (convicted **in** Virginia) Yes (pending **in** Virginia) No

If yes or pending, specify crime(s): _____

Yes(convicted **outside** Virginia) Yes (pending **outside** Virginia) No

If yes or pending, specify crime(s) and state, or other location: _____

2. Have you ever been the subject of a founded complaint of child abuse or neglect **within or outside** the Commonwealth?

Yes (**in** Virginia) No (**in** Virginia)

Yes (**outside** Virginia) No (**outside** Virginia)

If yes or pending, specify state, or other location: _____

I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification.

Signature Date

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DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LICENSING PROGRAMS
(Model Form)

Explanation of Sworn Statement or Affirmation

Requirement: Sections 63.2-1704, 63.2-1720, 63.2-1721, 63.2-1722, 63.2-1724 and 63.2-1725 of the *Code of Virginia* (Code) require individuals to provide a sworn statement or affirmation to a licensing, approving or hiring authority, facility, or agency prior to licensure, registration, approval, employment, or provision of volunteer services. A sworn disclosure or affirmation is a statement completed by a person attesting to whether he has ever been: (i) convicted of or the subject of pending charges of any crime within the Commonwealth or equivalent offense outside the Commonwealth, or (ii) the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. Additionally for family day homes, the person affirms if he, or if he knows that any person who resides in the home, has a sex offense conviction or is the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. The statement or affirmation must be made available to the Department of Social Services' representative.

Who must comply: These individuals must provide sworn statements or affirmations:

- Applicant upon application for licensure or registration as a child welfare agency, and any subsequent person designated as applicant, licensee, or registrant;
- Agent at the time of application who is or will be involved in the day-to-day operation of the child welfare agency or who is or will be alone with, in control of, or supervising one or more of the children and any subsequent person designated as agent who will be involved in the day-to-day operation or will be alone with, in control of, or supervising one or more of the children;
- Any other adult living in the home of an applicant for licensure or registration or approval as a family day home, or any existing employee or volunteer, and subsequent employee or volunteer or other adult living in the home;
- Prospective foster or adoptive parent;
- Operator of family day home requesting approval by family day system;
- Person who signs the statement of intent to operate a religious exempt child day center;
- Any person who will be expected to be alone with one or more children enrolled in a religious exempt child day center; and
- Any employee or volunteer of a licensed, registered, or approved facility who is involved in the day-to-day operations or who is alone with, in control of, or supervising one or more children.

Note: Any other child day center or family day home that has not otherwise met these requirements, and applies to enter into a contract with a local department to provide child care services to clients of a local department, must also submit a sworn statement or affirmation.

Exception: a parent-volunteer is not required to provide a sworn statement or affirmation. A parent–volunteer is a person supervising, without pay, a group of children that includes the parent-volunteer's own child in a program that operates no more than four hours per day, provided that the parent-volunteer works under the direct supervision of a person who has received satisfactory background checks as provided for in the Code.

Any person making a materially false statement regarding any such offense is guilty of a Class 1 misdemeanor.

Further dissemination of the sworn statement information is prohibited other than to the Commissioner's representative or a federal or state authority or court in order to comply with an express requirement in the law for that dissemination.

Consequence: If a person required to submit a sworn statement or affirmation has been: (i) convicted of a barrier crime (specified below), or (ii) convicted of any other felony in the last five years, or (iii) the subject of a founded complaint of child abuse or neglect:

- Licensure, registration or approval of a child welfare agency is prohibited;
- Licensure, registration or approval will be revoked and renewal of a license or registration or religious exempt status will be denied;
- Religious exempt status will be revoked; and
- The child welfare agency will not be permitted to receive federal, state or local child care funds.

Exception: A child-placing agency may approve as an adoptive parent an applicant convicted of not more than one misdemeanor of assault and battery, as defined in §63.2-57 of the Code, not involving abuse, neglect or moral turpitude, provided ten years have elapsed following the conviction.

Exception: A person who wants to operate or to volunteer or work at a facility covered by this regulation, but who is disqualified because of a criminal conviction, or a criminal conviction in the background check of any other adult living in a family day home governed by this regulation may apply for a waiver if: 1) a non-barrier crime felony conviction occurred less than five years ago, or 2) any other adult living in the home of a state regulated family day home applicant or provider has been convicted of not more than one misdemeanor offense of assault and battery or assault and battery against a family or household member. This other adult may not be an assistant or substitute provider.

Barrier crime defined: "Barrier crime" means a conviction identified in the Code at §63.2-1719. The convictions, and Code references, are: murder or manslaughter as set out in Article 1 (§ 18.2-30 et seq.), malicious wounding by mob as set out in § 18.2-41, abduction as set out in subsection A of §18.2-47, abduction for immoral purposes as set out in § 18.2-48, assault and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.), robbery as set out in § 18.2-58, carjacking as set out in § 18.2-58.1, extortion by threat as set out in § 18.2-59; felony stalking as set out in § 18.2-60.3, sexual assault as set out in Article 7 (§ 18.2-61 et seq.), arson as set out in Article 1 (§ 18.2-77 et seq.), burglary as set out in Article 2 (§ 18.2-89 et seq.), any felony violation relating to possession or distribution of drugs as set out in Article 1 (§ 18.2- 247 et seq.), drive by shooting as set out in § 18.2-286.1, use of a machine gun in a crime of violence as set out in § 18.2-289, aggressive use of a machine gun as set out in § 18.2-290, use of a sawed-off shotgun in a crime of violence as set out in subsection A of § 18.2-300, pandering as set out in § 18.2-355, crimes against nature involving children as set out in § 18.2-361, incest as set out in § 18.2-366, taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1, abuse and neglect of children as set out in § 18.2-371.1, failure to secure medical attention for an injured child as set out in § 18.2-314, obscenity offenses as set out in § 18.2-374.1, possession of child pornography as set out in § 18.2-374.1:1, electronic facilitation of pornography as set out in § 18.2-374.3, abuse and neglect of incapacitated adults as set out in § 18.2-369, employing or permitting a minor to assist in an act constituting an offense under Article 5 (§ 18.2-372 et seq.) as set out in § 18.2-379, delivery of drugs to prisoners as set out in § 18.2-474.1, escape from jail as set out in § 18.2-477, felonies by prisoners as set out in § 53.1-203; or an equivalent offense in another state.

Sex offense defined: "Sex offense felony for family day homes" means conviction of a felony in violation of §§ 18.2-48, 18.2-61, 18.2-63, 18.2-64.1, 18.2-67.1, 18.2-67.2, 18.2-67.3, 18.2-67.5, 18.2-355, 18.2-361, 18.2-366, 18.2-369, 18.2-370, 18.2-370.1, 18.2-371.1 or § 18.2-374.1, that prohibits a sex offender or child abuser from residing in a family day home. The description of the *Code* sections are abduction; actual or attempted rape; carnal knowledge of a child between thirteen and fifteen years of age; carnal knowledge of a juvenile under the purview of the Juvenile and Domestic Relations District Court, or juvenile committed to the custody of the State Department of Juvenile Justice; actual or attempted forcible sodomy or object sexual penetration; aggravated sexual battery; attempted sexual battery; taking or detaining a person or consenting to the taking of a person for prostitution or unlawful sexual intercourse; crimes against nature; incest; abuse and neglect of incapacitated adults; taking indecent liberties with children; abuse and neglect of children; indecent liberties by a person in a custodial or supervisory relationship; and production, publication, sale, possession with intent to distribute, financing, etc. of sexually explicit items.

Providence Nursery School

A Co-operative Preschool

(FORM 10)

Emergency Care and Contact Information

Student Information

Child's Full Name:_____ **Sex**: F M

Class: CDO 2s 3s 3/4s 4s Summer Program

Name child likes to be called: _____ **Birth date**: _____

Health Information:
Below check any current health condition:

Allergies (please be specific):

Foods_____ Asthma

Medicines_____ Diabetes

Bee sting or insect bite_____ Hearing problems

Other_____

Physical disability (please be specific):_____

Vision problems (please be specific):_____

Glasses Contacts

Other health concerns (please be specific):_____

Please provide **specific instructions** for action to be taken for any condition listed above (i.e.: call parent, 911, etc.):

***Note**: If an Epipen is to remain at the school, a doctor's prescription and Written Medical Consent form must accompany the Epipen. If any other precautions are to be taken for any illness or allergy, a doctor's diagnosis and note from doctor must accompany the request for special accommodations.*

Child's Physician: _____ **Telephone:** _____

Contact Information

Student resides with (please check all that apply):
Both Parents Mother Father Guardian

Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school, unless a court order or other legal document states otherwise. It is your responsibility to provide a copy of that document to Providence Nursery School.

Mother Guardian

Last First Middle

Address City Zip

Home Phone Cell Phone

Employer Work Phone

Email Address

Father Guardian

Last First Middle

Address City Zip

Home Phone Cell Phone

Employer Work Phone

Email Address

Please list two (2) people we may contact if parents cannot be reached, who have permission to make decisions concerning your child in the event of an emergency. Please check the box if this person also has your permission to pick up your child from school. If there are additional people who have

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permission to pick up your child, please add them in the available spaces. Please be sure to give full address and phone numbers for these contacts.

Name: _____ Relationship: _____

Address_____ Phone: _____

Name: _____ Relationship: _____

Address_____ Phone: _____

Name: _____ Relationship: _____

Address_____ Phone: _____

Name: _____ Relationship: _____

Address_____ Phone: _____

If child attends Providence AND another school, please give name of that school**:** _____

Please list any person(s) NOT authorized to pick up child (Note: appropriate paperwork such as divorce decree shall be attached if a parent is not allowed to pick up the child):

Agreements

1. The parent/guardian gives authorization for the child to participate in field trips. Yes No
2. The parent/guardian gives permission for the school to use the child's photograph for educational and/or marketing purposes. Note: the child's name will never accompany photograph. Yes No
3. Providence Nursery School agrees to notify the parent/guardian if and when the child becomes ill, and the parent/guardian agrees to pick up thereafter as soon as possible.
4. The parent/guardian authorizes Providence Nursery School to obtain immediate medical care if any emergency occurs when the parent cannot be located immediately.
5. The parent/guardian agrees to inform Providence Nursery School within 24 hours or the next business day after the 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 that must be reported immediately.
6. Other: _____

Signatures:

Mother or Guardian: _____ **Date**: _____

Father or Guardian: _____ **Date**: _____

Co-Presidents: *Marta Davis and Kelly Volciak* **Date:** *May 2, 2011*

Note: A copy of this form should accompany child on all field trips.

Providence Nursery School

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Proof Of Identity

The State of Virginia requires us to have the information below on file, under regulations designed to help locate missing or abused children.

Parents' Names: _____

Child's Name: _____

Class**:** CDO 2s 3s 3/4s 4s Summer Program

Has your child ever attended a child day care or preschool program other than PNS? _____

If yes, give the name your child used at that program and the following information about that program:

Child's Name: _____ Child's Name: _____

Program: _____ Program: _____

Address: _____ Address: _____

_____ _____

In 1998, the state of Virginia instituted a PROOF OF IDENTITY REQUIREMENT for all children enrolled in a school/day care licensed by the state. At the Spring Coffee, Back-To-School Night, or other arranged date within 7 days of your child's first day of school, you must provide an original copy of a birth certificate or other identification *to be viewed* by an officer of the school. An officer will record the document number for our files. *For a full list of acceptable forms of identification, please see the back of this form.*

If you need to obtain a birth certificate for your child, please contact the Virginia Department of Health's Office of Vital Records at www.vdh.state.va.us/Vital_Records/index.htm or (804) 662-6200. If your child was born in another state, please contact their Bureau of Vital Statistics.

(For PNS Use Only)

Child's Name: _____ Child's DOB: _____

Document Type: _____ Document #: _____

Document Issue Date: _____ Child's Place of Birth: _____

Viewing Officer's Name: _____ Date Viewed: _____

Please Note: You will only need to fill out this form upon initial enrollment at Providence. Proof of Identity is valid for the ***entire period of time*** *a child is enrolled.*

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State of VA Proof of Identity Requirements

The Code of Virginia section 63.1-196.3 requires all children under the age of 13 when first enrolled in a Virginia school or camp to present proof of identity and age as well as information regarding previously attended child day care programs and schools.

All children enrolled in Providence Nursery School must present proof of identity for review by school/camp personnel when first enrolled. All documents will be returned, if requested.

The proof must be an **original** document from the following list:

- A certified copy of child's birth certificate
- Birth registration card
- Notification of birth (hospital, physician or midwife record)
- Valid 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/her designee of a public school in the U.S. that a certified copy of the child's birth was previously presented
- Copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent

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 or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, 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, 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 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

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ❑ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Certification of Immunization 04/07

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:** _____

Virginia Department of Social Services/Child Protective Services
Central Registry Release of Information Form

Part I: INSTRUCTIONS - Read all instructions before completing form: Incomplete forms will be returned.

1. Type or print legibly in ink. Indicate N/A if a question is not applicable
2. Submit a separate form for each individual whose name is to be searched. MUST USE THIS FORM BEGINNING 11/01/09
3. Provide proof of identity and sign Part III in the presence of a Notary Public.
4. ***Enclose a $7.00*** money order, company /business check or cashiers check payable to: **Virginia Department of Social Services** (unless waived) **DO NOT SEND CASH or PERSONAL CHECKS.** This fee is nonrefundable. $25 will be charged for checks returned for insufficient funds.
5. Search results disseminated beyond the requesting agency/individual named below are not considered official.
6. Mail completed form to: **VA Dept. of Social Services, 801 East Main St, 6th floor, OBI Search Unit, Richmond VA 23219-2901**

MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search

Name **Address:** **City** **State** **Zip Code** **Contact Person** **Contact's Phone Number**	**Payment Code/ Fips Code** **(If assigned by Central Registry Unit)** **Mandatory for all coded agencies**

Purpose of Search, Check one: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☐ Other Employment ☐ School Personnel ☐ Volunteer ☐ Other

Part II: TO BE COMPLETED IN FULL, BY INDIVIDUAL WHOSE NAME IS BEING SEARCHED

Identifying Information for Person Being Searched:

Last Name	First Name		Full Middle Name – no initials (if name is initial only state Initial Only)
Maiden Name	Sex ☐ Male ☐ Female	Race	Date of Birth MM/DD/YY	Social Security Number
Driver's License Number	Other names Used by the Individual (Nicknames, previous married names, etc.)		
Current Address Street	Current Address City	Current Address State	Current Address Zip Code
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency

CURRENT SPOUSE INFORMATION ☐ **CHECK HERE IF NOT CURRENTLY MARRIED**

Last Name	First Name	Full Middle Name	Maiden Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY

ALL PREVIOUS SPOUSES ☐ **CHECK HERE IF NOT PREVIOUSLY MARRIED**

Last Name	First Name	Full Middle Name	Maiden Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Maiden Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY

Full Names of All Children: (Include Adult Children, Step, Foster, Children Not Living with you. Attach additional paper if needed)

☐ Check here if you do not have children

Last Name	First Name	Full Middle Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex ☐ Male ☐ Female	Race	Birth Date MM/DD/YY

over

Virginia Department of Social Services/Child Protective Services
Central Registry Release of Information Form

Part III: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which as been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of Person to Be Searched Parents' Signature (Needed if child is 17 years old or younger)

Part IV: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____day of _____, 20 _____

_____ _____

Notary Public Signature **Notary Number**

My Commission Expires: _____

Do not write below this line.

Part V: Findings - To be completed by OBI Central Registry staff only.

CENTRAL REGISTRY FINDINGS

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to Central Registry Unit in order for us to make a determination:

_____

_____

_____

_____

_____

Worker: _____ Date: _____

2. _____Based on information provided by the Local Department of Social Services, we have determined that _____is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____ Dept.of Social Services in reference to referral _____phone#_____

_____ Dept.of Social Services in reference to referral _____phone#_____

3 _____As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry Child Abuse/Neglect.

Signature of worker completing search: _____ Date: _____

OBI staff only