New Student Enrollment Paperwork

1. Enrolment Agreement (Standard Contract in which all persons liable for tuition payment must sign)
2. Emergency Contact/Parent Consent Form (list two separate, COMPLETE addresses and phone numbers of emergency contacts whom you authorize to pick up your child in the event of an emergency)
3. Identity Verification/Proof of Birth (we must see a birth certificate, a passport, birth letter)
4. Enrollment Authorization (authorizing your child to participate In Little Blossoms sponsored activities
5. Permission to Photograph (grants or denies permission to photograph your child)
7. Virginia School Entrance Health Form (page 1 completed by parent/guardian: pages 2-4 MUST be completed by a doctor. Physical must be dated within the last 6 months for children under the age of 2 and within the last year for children over the age of 2)
8. Enrollment Application (Please verify you have turned this in previously when registration was paid)

Additional Items to Bring:

2-3 sets of seasonally appropriate clothing
Diapers, wipes, diaper cream and sunscreen
Water Bottle with fresh water
A small blanket for nap time

Please feel free to email or call us If you have any questions when completing this paperwork.

Little Blossoms Daycare,LLC

CHILD'S RECORD

- **INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.**
- **THE COMPLETED FORM MUST BE KEPT IN THE CHILD'S RECORD AND THE FIRST PAGE UPDATED ANNUALLY.**
- **THE INFORMATION IN THIS FORM IS REQUIRED BY FAMILY DAY HOME STANDARD 8VAC20-800-60**

Child's Full Name	Nickname	Sex	Birth date
Street Address / City / State / Zip		First Day of Attendance Last Day of Attendance	
If Child Attends School, Give Name of School			Grade

EMERGENCY INFORMATION

Allergies and intolerance to food, medications, or other substances. Actions to take in emergency situation.
Chronic Physical Problems/Diseases; Pertinent Development Information; Special Accommodations Needed; Special Instructions to Provider

Father's Full Name	Phone	Employer	
Father's Employer's Address (Street Address)			Father's Work Phone
Father's Home Address (Street Address) (enter "Same" if address is the same as the child's)			
Mother's Full Name	Phone	Employer	
Mother's Employer's Address (Street Address)			Mother's Work Phone
Mother's Home Address (Street Address) (enter "Same" if address is the same as the child's)			
Child's Physician	Office Address (Street Address) City / State / Zip		Phone
Name of Child's Medical Insurance			Policy Number
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address City / State / Zip		Phone
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address City / State / Zip		Phone
Person(s) Authorized to Pick Up Child (Appropriate custodial paperwork (custody order or other court order) shall be attached if a parent is not allowed to pick up the child)			

_____ _____ **(Valid for One Year)**

Parent Signature Date

1st yr. review _____ _____ _____

Parent Signature Date

2nd yr. review _____ _____ _____

Parent Signature Date

3rd yr. review _____ _____ _____

Parent Signature Date

Little Blossoms Daycare,LLC
CHILD'S RECORD

Mother's Email: _____ Father's Email: _____

PROOF OF AGE AND IDENTITY (must be obtained from parent within 7 business days of child's first day of attendance)			
Names & Locations (City and State) of Previous Child Day Care Programs & Schools Attended			
Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Proof of Age Other Than Birth Certificate*		Date Documentation Viewed	Person Viewing Documentation

NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCY (if parent does not provide proof of child's age and identity within 7 business days of child's first day of attendance)		
Date of Notification	Name of Agency Notified	Name of Individual Notified

*Proof of age and identity may be verified by viewing one of the following: certified birth certificate; birth registration card; notification of birth, i.e., hospital, physician, or midwife record; passport; copy of the placement agreement or other proof of the child's identity from a child placing agency; original or copy of a record or report card from a public school in Virginia; signed statement on letterhead stationery from a public school principal or other designated official that assures the child is or was enrolled in the school; or child identification card issued by the Virginia Department of Motor Vehicles.

EMERGENCY MEDICAL AUTHORIZATION

I authorize _____ to obtain immediate care and consent to emergency medical
Name of Licensed Provider
procedures upon, the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to _____ if an emergency occurs and I cannot be located immediately.
Name of Child

It is also understood that this agreement covers only those situations which are true emergencies and only when I cannot be reached. Otherwise I expect to be notified immediately.

_____ _____
Signature of Parent Date

The child's Emergency Information and the Emergency Medical Authorization must be made available to a physician, hospital, or emergency responders in the event of a child's illness or injury.

ADDITIONAL DOCUMENTS REQUIRED FOR CHILD'S RECORD

____ Immunization and Physical Examination Record Form MCH213 F (signed by physician, physician's designee, or health official)

____ Information for Parents (signed by parent)

____ Policy for the Administration of Medications (signed by parent)

____ Liability Insurance Declaration (signed by parent)

____ Provisions of the Home's Emergency Preparedness and Response Plan (signed by parent)

As Applicable:

____ General Permission for Regularly Scheduled Trips (signed by parent)

____ Special Field Trip Permission (signed by parent)

____ Medication Consent (signed by parent) ***Valid for 10 days unless also signed by physician**

____ Permission to Participate in Swimming or Wading Activities (signed by parent) ***Valid for one year**

____ Injury Record(s)

If Child with Special Needs is in Care:

____ Staffing Recommendation for a Child with Special Needs (signed by parent, provider, and Licensing representative)

____ Individual Health Care/Special Needs (signed by licensed health care professional)

Little Blossoms Daycare, LLC

EMERGENCY INFORMATION

NAME OF CHILD'S PHYSICIAN: _____ PHONE: _____

PEOPLE TO CONTACT IF PARENTS CANNOT BE REACHED:

NAMES ADDRESSES RELATIONSHIP TO CHILD PHONE

Name	Address	Phone	Relation to child

PERSONS AUTHORIZED TO PICK UP CHILD: _____

PERSONS NOT AUTHORIZED TO PICK UP CHILD:_____

IF CHILD ATTENDS ANOHER /PREVIOUS SCHOOL ALSO, GIVE NAME OF SCHOOL

_____GRADE: _____

Parents Signature: _____ Date: _____

Little Blossoms Daycare, LLC

Emergency Contact and Parental Consent Form

Child's Name: _____

Address: _____

Telephone: _____ Birth Date: _____

Mother's Name/Legal Guardian:_____
Address:_____
Email:_____ **Cell:** _____
Work Address:_____ **Work Phone** _____

Father's Name/Legal Guardian: _____
Address:_____
Email:_____ **Cell :**_____
Work Address:_____ **Work Phone** _____

Emergency ***Contact #1*** (Other than Parents**)**_____
Address:_____
Phone Number_____ **Cell** _____ **Work**_____

Emergency ***Contact #2*** (Other than Parents**)** _____
Address:_____
Phone Number_____ **Cell** _____ **Work**_____

Doctors Name: _____ **Phone #** _____

Special Disabilities *(N/A if none)***:** _____

Medical/Dietary info needed in event of emergency *(N/A if none)*_____

Special Diet *(N/A if none)* _____

Allergies *(N/A if none)* _____

Allergy Action Plan: _____

Medications, special conditions *(N/A if none)* _____

PARENT SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

Obtaining Emergency Medical Care_____

Administration of minor first aid _____

Posting your child's name and allergy on our Daycare allergy list if necessary _____

Water activities when weather permit_____

Outside Playground _____

Parent Signature _____ **Date** _____

Little Blossoms Daycare, LLC

Enrollment Authorizations

Child's Name: (Last)_____(First)_____Date_____

Emergency Medical Care Authorization

I give my permission for the Daycare to seek emergency medical care for my child of deemed necessary by the staff and or administration, and that I will be notified as soon as possible.

Signature of Parent/Guardian: _____

Emergency Care Authorization

I give my permission for emergency care decisions to be made by the daycare staff regarding my child, in the event of an emergency that impedes regular daycare operations. I understand that the daycare will notify me by telephone, as soon as possible.

Signature of Parent/Guardian: _____

Participation Permission

I hereby grant permission for my child to participate in any of the childcare activities and to use any of the play equipment to include all indoor and outdoor toys, blocks, climbing structures, etc.

Signature of Parent/Guardian: _____

Water Activity Permission

I hereby grant permission to the Daycare to include my child in supervised water activities. My child's swimming skill level is: a)____ cannot swim b)____swims w/assistance c)____comfortable swimmer

Signature of Parent/ guardian: _____

Publicity Participation

I give permission for my child to be photographed for publicity purposes and/or school activities and bulletin boards. I relinquish all rights, title and interest in the finished photographs and negatives.

Signature of Parents/Guardian: _____

Little Blossoms Daycare, LLC

Emergency Evacuation and Transportation Release

Please note our location in the unlikely event that we would need to evacuate the Daycare. We have provided the location and the phone number for your reference. If the Daycare is evacuated, we will do the following:

1. Line up the children as we do for a routine fire drill.
2. Take a head count from our attendance sheet and double check it with the children who are present.
3. Calmly walk the children out of the building to the front of the house where we practice in our monthly fire drills. Begin to walk, toward the front of the house.
4. The Staff will stay behind to "sweep" the building no child stayed behind.
5. We will begin to call each family to have you pick up your children from the safe location. Our primary responsibility in an emergency situation is to remove the children from the Daycare as safely as possible.

By signing this form, you understand our emergency evacuation procedures and will not hold the daycare at any fault.

Child's Name _____

Parent Signature_____ Date_____

Parent Signature_____ Date_____

Little Blossoms Daycare, LLC

PERMISSION TO PHOTOGRAPH OR VIDEO TAPE CHILD

PLEASE CHECK BOX IF YOU DO NOT WANT TO GIVE PERMISSION FOR YOUR CHILD TO BE PHOTOGRAPHED OR VIDEO TAPED. IF SO, PLEASE CHECK THIS BOX AND SIGN BELOW.

I hereby give permission to Little Blossoms Daycare, LLC to photograph and use picture(s) and/or video of my child/children and/or examples of their Daycare work.

1. Child's Name: _____
(Please print child's name)

2. Child's Name: _____
(Please print child's name)

Upon the following terms:

Little Blossoms Daycare, LLC undertakes to use the photograph(s) only in printed promotional materials, parent email, on-line publications, social media and on the Little Blossoms Daycare, LLC websites.

☐ Little Blossoms Daycare, LLC undertakes not to disclose the name or provide any details of any child in any way to any person or entity.

☐ Little Blossoms Daycare, LLC undertakes not to take any photos or video tapes of your child.

Little Blossoms Daycare, LLC and the parent/guardian named below agree that there shall be no remuneration for the use of any child's photographs, video or daycare work.

Date:_____

Parent/Guardian Name: _____
(Please print name)

Parent/Guardian Signature: _____

Little Blossoms Daycare, LLC

Office Use Only

Identity Verification

Place of Birth:	Birth Date:	Birth Certification Number:	Date Issued:
Other Form of Proof:			

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, c or other proof of the child's identity from a child placing agency,. 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.

Previous Childcare Programs and Schools Attended:

_____

_____

_____

Viewed by:_____ Date:_____

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

• • • Child's Full Given Name: _____ Nickname(s): _____ 2. Date of Birth: _____ 3. Parent / Guardian Name: _____ 4. Parent / Guardian Name: _____ 5. Parents are (circle one) together separated divorced other (Please explain) _____ 6. Names and ages of other people who live in the home:

_____

7. Pets in the home: _____

8. Over the course of this school year, I/we would like to see my child learn or work on the following skills or activities: _____

_____

9. The activities my child enjoys / excels in are: _____

_____

10. My child's favorite foods are: _____

_____

11. My child's least favorite foods are: _____

_____

12.Allergies: _____ Special Instructions related to allergies: _____ 13. Other dietary information: _____ 14. The best way to describe my child's personality is _____

_____ 15. My child has the following responsibilities at home: _____

_____

16. My child's fears or anxieties _____

17. Other important information: _____

Little Blossoms Daycare, LLC

Authorization form for the application of non-prescription topical ointment or cream, including but not limited to sunscreen, insect repellent, diaper ointment, or teething gel (with a physician's note for children under 2).
The product must be in the original container and, if provided by the parent, labeled with the child's name
Parents must be informed immediately of any adverse reaction
The product must not be used beyond the expiration date of the product
Sunscreen must have a minimum sunburn protection factor (SPF) of 15
Authorization Form must be completed for each non-prescription topical ointment or cream

Child Name _____ Age _____.

I authorize Little Blossoms Daycare, LLC staff to apply the following non-prescription topical ointment or cream to my child, as described below. I understand that these products will only be applied according to the product's label. Any deviations from the label will require a physician's written authorization. For children under two years, please ensure their age is represented on the label or provide physician's written authorization.

TOPICAL OINTMENT/CREAM	Where on the Body to be applied	When to be applied	Start Date	End Date	Expiration date	Parent/Guardian Initials

This authorization is effective until: _____ (the effective period must not exceed one calendar year from the date of the parent's signature below), place in child's file.

Parent/Guardian Signature: _____ Date: _____

Little Blossoms Daycare,LLC

Child's Name _____

LIABILITY INSURANCE DECLARATION

THIS FORM COMPLIES WITH THE REQUIREMENTS OF § 22.1-289.050 OF THE CODE OF VIRGINIA AND MUST BE MAINTAINED ON FILE IN THE FAMILY DAY HOME AT ALL TIMES WHILE THE CHILD IS IN ATTENDANCE AND FOR 12 MONTHS AFTER THE CHILD'S LAST DAY OF ATTENDANCE.

I have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Education ($100,000 per occurrence and $300,000 aggregate).
_____ Yes _____ No

I, _____, acknowledge having received the
(Signature of parent or guardian)
above-referenced notification on _____.
(Date)

☐ **I no longer have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Education effective _____.**
(Date)

I, _____, acknowledge having received the
(Signature of parent or guardian)
above-referenced notification on _____.
(Date)

Little Blossoms Daycare, LLC

Medication Administration – Decision to Administer

(Required by Standards for Licensed Family Day Homes 8VAC20-800-60

Provider's Name (please print):	Name of Family Day Home:
Dipali Mathur	Little Blossoms Daycare, LLC

I have made the following decision regarding the administration of medications to a child in my family day home:

☐ I (or other caregivers) WILL NOT administer any medications–prescription or non-prescription medication.

☐ I (or other caregivers) WILL administer ONLY prescription medication.

☐ I (or other caregivers) WILL administer ONLY EpiPens and prescription topical creams and ointments.

☐ I (or other caregivers) WILL administer ONLY non-prescription medication.

☐ I (or other caregivers) WILL administer BOTH prescription and non-prescription Medication.

☐ I (or other caregivers) WILL administer ONLY non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellant.

Authorized Caregivers to Administer Prescription and Non-Prescription Medications

Only a caregiver who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications and is listed as a medication administrator in this document will be permitted to administer prescription medications and non-prescription medication (except non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellant) in my family day home.

Medication administrators will administer prescription medications in accordance with the physician's or other prescriber's instructions and in accordance with the standards of practice in the MAT training.

Medication administrators will administer non-prescription medications at the dose, duration and method of administration specified on the manufacturer's label for the age or weight of the child.

I understand that any individual listed in this section as a medication administrator is approved to administer prescription medications using the following routes: topical, oral, inhaled, eye, and ear, medication patches and epinephrine using an auto-injector device.

I understand that if a child in my family day home requires prescription medication to be administered rectally, vaginally, by injection or by another route not listed above, I will follow the procedures outlined in the MAT training for children with special health care needs.

Medication Administrator(s)

Current MAT certificates (or documentation of licensure to administer prescription medications), current age-appropriate first aid certificates, and current CPR certificates for the caregivers listed below will be kept in the caregivers' records and be available upon request.

Caregiver Name: _____

Caregiver Name:_____

Confidentiality Statement

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

ADA Statement

I understand the provisions of the Americans with Disabilities Act. If any child enrolled in my family day home now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the family day home to meet the needs of the child (for further information on ADA seek legal counsel and/or go to the following website: www.usdoj.gov/crt/ada/chcaflyr.htm). If my family day home can meet the needs of the child without making a fundamental alteration to the program and the child will need regular or emergency medication, I will ensure that I have a caregiver in my family day home who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications.

Provider Statement

I understand that it is my responsibility to follow my POLICY FOR THE ADMINISTRATION OF MEDICATION and all health and infection control regulations applicable to my family day home.

I will verify and document the credentials for all new caregivers before the caregiver is allowed to administer prescription or non-prescription medications (except non-prescription topical skin products) to any child in my family day home.

My POLICY FOR THE ADMINISTRATION OF MEDICATION will be made available to parents at enrollment, whenever changes are made and upon request.

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Sign:	Date:
Parent's Sign:	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 earlier 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 Code_____

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: _____-_____-_____

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

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)			

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 Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** **Hispanic** **Non-Hispanic**

IMMUNIZATION	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN**				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
Tdap Vaccine booster	**1**				
Poliomyelitis Vaccine (IPV, OPV)	**1**	**2**	**3**	**4**	**5**
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	**1**	**2**	**3**	**4**	
Rotavirus Vaccine (RV) only for children < 8 months of age	**1**	**2**	**3**		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	**1**	**2**	**3**	**4**	
Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	**1**	**2**			
Measles Vaccine (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	**1**	**2**	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	**1**	**2**	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	**1**	**2**	**3**	**4**	
Hepatitis **A** Vaccine	**1**	**2**			
Meningococcal **ACWY** Vaccine	**1**	**2**			
Meningococcal **B** Vaccine	**1**	**2**	**3**		
Human Papillomavirus Vaccine (HPV)	**1**	**2**	**3**		
Influenza (Yearly)	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

Certification of Immunization

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. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____|.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth:_____/_____/_____Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

- ❑ Age / gender appropriate history completed
- ❑ Anticipatory guidance provided

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				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading____ mm TST/IGRA Result: □ Negative □ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ □ Normal □ Abnormal

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.

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Referred

	1000	2000	4000
R			
L			

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**

□ Permanent Hearing Loss Previously identified: □ Left □ Right

□ Hearing aid or another 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

□ Problems Identified: Referred for Treatment

□ No Problem: Referred for prevention

□ No Referral: Already receiving dental care

☐ **Unable to perform**

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* □ *epinephrine auto-injector* □ other::_____

____In**dividualized 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) ☐ **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:**_____

Little Blossoms Daycare, LLC

PROVISIONS OF THE EMERGENCY PREPAREDNESS AND RESPONSE PLAN

Before the child's first day of attendance, parents must be informed of the provisions in the home's Emergency Preparedness and Response Plan (Standards for Licensed Family Day Home 8VAC20-800-70).

To the Parent(s) of _____ *(child's name)*:

This letter is to assure you of our concern for the safety and welfare of children attending

Little Blossoms Daycare,LLC .

Our Emergency Plan provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation:* Children are evacuated to a safe area near the home in the event of a fire, etc.
- *In-place sheltering*: Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the home is the best immediate response.
- *Relocation*: Total evacuation of the home may become necessary if there is a danger in the area. In this case, children will be taken to a relocation site at

Ashburn Library located at 43316 Hay Rd, Ashburn, VA 20147

We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information.

We will have your contact information with us and you will be contacted as soon as possible following any emergency action so that arrangements can be made for you and you child to be safely reunited.

In your child's record at this home are the names of persons you have authorized to pick up your child if you not able to do so. Please ensure that only those persons you have authorized attempt to pick up your child.

We specifically urge you **not** to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, we ask for your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, please let us know.

_____ _____

Parent Signature Date