Enrollment Checklist

The following must be on file at the time of admission:

____ Enrollment Application. Please make sure that your Emergency Contacts are **LOCAL.**

____ Health forms including updated immunizations and physical

____ Proof of Identity – This can be a Birth Certificate, Proof of Birth Letter, or a Passport.

____ Tuition Express Deduction Authorization (if you elect to have your tuition automatically deducted from your account on the 1st or the 15th of the month)

____ Parent Questionnaire

____ Authorization for Over-the-Counter Skin Care Products (ifskin care products are to be administeredattheCenter (diaper cream, sunscreen, etc.)

____ Parent Manual Signature in the "Agreement" Section of the Enrollment Application

____ Parent Manual Signature on Handbook Receipt Page (will be received at registration appointment)

ENROLLMENT APPLICATION

Please Print

For part-time programs, please circle days of attendance:

Program:_____

Full-time
Part time 3-day: M T W TH F
Part-time 2-day: M T W TH F

Start Date:_____
Tuition Schedule: Weekly or Monthly

GENERAL INFORMATION

Child's Name _____ Nickname _____ Date of Birth _____ Gender _____

Address _____ Home Phone _____

Previous Child Day Care Programs Attended _____ Name of school / program attended simultaneously _____

PARENT(S)/GUARDIAN(S) INFORMATION

Parent's Name _____ Cell Phone _____ Email Address _____

Home Address _____ Home Phone _____ Alternate E-mail Address _____

Employer _____ Work address _____ Work Phone _____

Parent's Name _____ Cell Phone _____ Email Address _____

Home Address _____ Home Phone _____ Alternate E-mail Address _____

Employer _____ Work address _____ Work Phone _____

EMERGENCY INFORMATION

Please describe any allergies or intolerance to food, medication, etc. and action to take in an emergency:

_____

_____

Name of Child's Pediatrician _____ Telephone number _____

TWO PEOPLE TO CONTACT IF PARENT(S) CANNOT BE REACHED WITHIN 1 HOUR:

Please be sure to provide a complete address including zip code and telephone number for all contacts listed. (Please do not include your own name here.) **THESE CONTACTS NEED TO BE LOCAL.**

Name _____ Address _____ Phone: CELL WORK HOME

Name _____ Address _____ Phone: CELL WORK HOME

PERSON(S) AUTHORIZED TO PICK UP CHILD

Photo identification is required. Fontanelle Academy of Early Learning reserves the right to copy this identification to keep in your child's record. Your child will not be released to any person without written authorization. **Please be sure to provide a complete address including zip code and telephone number for all contacts listed. (Please do not include your own name here.)**

Name	Address	Phone: CELL WORK HOME
Name	Address	Phone: CELL WORK HOME

PERSON(S) NOT AUTHORIZED TO PICK UP CHILD

**Appropriate paperwork, such as custody papers, must be kept in the child's file if a parent is not allowed to pick up the child.

PHOTO WAIVER

I give my permission for my child to be included in school pictures and consent to the use of those pictures by Fontanelle Academy of Early Learning on its website. My child's picture will not be used in any printed promotional materials such as brochures, newspaper advertisements, etc. without my express written authorization, which shall be separately required for each such use.

AGREEMENTS

1. Fontanelle Academy of Early Learning 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) authorizes Fontanelle Academy of Early Learning to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately.
3. The parent(s)/guardian (s) agrees to notify Fontanelle Academy of Early Learning within 24 hours after the child or a member of the immediate household has developed a communicable disease.

Parent's Signature _____ Date _____

Director's Signature _____ Date _____

IDENTITY VERIFICATION

Please provide us with 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 United States 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.

OFFICE USE ONLY:

Place of Birth: _____ **Birth Date:** _____

Birth Certificate Number: _____ **Date Issued:** _____

Other Form of Proof: _____

Person Viewing Documentation: _____ **Date Viewed:** _____

Date of notification of local law enforcement agency (when required proof of identity is not provided): _____

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 Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

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

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

_____

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

_____

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

Please provide the following information:

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

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

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

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
*Tdap booster (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 <60 months of age	**1**	**2**	**3**	**4**	
Measles, Mumps, Rubella (MMR vaccine)	**1**	**2**			
*Measles (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
*Rubella	**1**		Serological Confirmation of Rubella Immunity:		
*Mumps	**1**	**2**			
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	**1**	**2**	**3**		
*Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	**1**	**2**			
Meningococcal Vaccine	**1**				
Human Papillomavirus Vaccine	**1**	**2**	**3**		
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

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

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.)

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	□	□	□

TB Screening: □ 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: □ Positive □ Negative
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.

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

Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____

(Child's name)

Fontanelle Academy of Early Learning has my permission to administer the following medication:

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____

(Start date) **(End date)**

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

Section B: to be completed by child's physician

I, _____ certify that it is medically necessary for the medication(s) listed

(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.

(Child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____

(Start date) **(End date)**

Physician's Signature: _____ **Date**: _____

07/19

Physicians Phone: _____

Authorization Form for
Non-prescription Over-the-Counter Skin Products

INSTRUCTIONS:
This form must be completed by the parent/guardian to authorize the use of:

- Sunscreen
- Diaper ointment or cream
- Insect repellent

_____ has my permission to apply the non-prescription
(Name of Provider)

over-the-counter (OTC) skin product listed below to my child, _____.
(Child's name)

Product Name: _____

Known Adverse Reactions (if any): _____

_____

- All OTC products must:
  - Be in the original container and, if provided by the parent, labeled with the child's name
  - Be used according to manufacturer's recommendation and instructions for application
  - Not be used beyond the expiration date of the product

- Sunscreen:
  - Must have a minimum sunburn protection factor (SPF) of 15
  - Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
  - Children nine yrs. and older may self administer sunscreen if supervised

- Diaper ointment/cream and Insect repellents:
  - Shall be kept inaccessible to children
  - Record of use shall be kept that includes child's name, date, frequency of application, and any adverse reactions

This authorization is effective from: _____until: _____
(Start date) **(End date)**

Parent's Signature: _____ Date: _____

07/19

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I (we) hereby authorize (business name) Fontanelle Academy of Early Learning to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

~~SECTION A (Credit Card)~~

~~Cardholder Name~~ ~~Phone #~~

~~Cardholder Address~~ ~~City~~ ~~State~~ ~~Zip~~

~~Account Number~~ ~~Expiration Date~~

Cardholder Signature Date

SECTION B (Bank Account)

Your Name Phone #

Address City State Zip

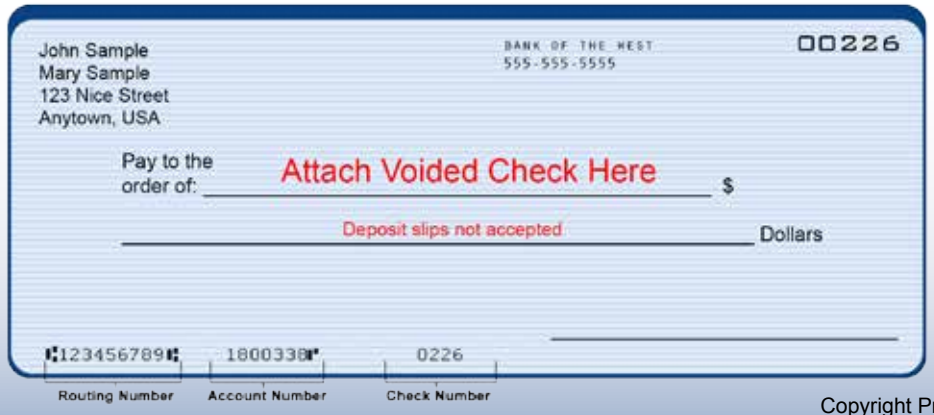
Bank or Credit Union Name Bank or Credit Union Address City State Zip

Routing Transit Number (see sample below) Account Number (see sample below) ☐ Checking ☐ Savings

Authorized Signature Date

For Official Use Only

Date Received
Employee Signature



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PARENT QUESTIONNAIRE FOR INFANTS & TODDLERS

Dear Parents,
Please fill out this questionnaire to help us provide your child with a smooth transition and a successful child care experience. Thank you!

CHILD'S NAME _____

DATE OF BIRTH _____

PHYSICAL DEVELOPMENT
Does your child:

_____ sit with support	_____ sit unassisted	_____ crawl forward/backward
_____ stand	_____ walk with assistance	_____ walk unassisted
_____ run	_____ go up steps	_____ go down steps

SLEEPING HABITS
My child usually naps _____ times/day from: _____ to _____
from: _____ to _____
from: _____ to _____

My child sleeps at night from _____ p.m. to _____ a.m.

Does your child have any sleep disturbances?

Does your child sleep with any special object?

Does your child sleep in her/his crib at night? Yes _____ No* _____
* If No, please explain.

EATING HABITS

_____ breast-fed (how long?) _____

_____ bottle-fed (how long?) _____

_____ weaned (date) _____

My child drinks ____ ounces of milk every ____ hours.

My child eats every ____ hours.

Type of formula now in use: _____

_____ eats table food _____ drinks from a bottle _____ holds own bottle

_____ drinks from a cup _____ uses a pacifier _____ can feed self

TOILETING

Child wears: diapers _____ all day _____ sleeping only

underpants _____ all day

Training process: bowel control (date)_____ bladder control (date)_____

Does your child ask to go to the bathroom?

What phrases/words do you use for urinating?

What phrases/words do you use for bowel movements?

If toilet training is in process, please describe routines/methods you use:

PLAY & SOCIAL INTERACTION

Has your child ever attended or been enrolled in:

_____ a child care center at what age? _____

_____ a family day care home at what age? _____

_____ a babysitter's home at what age? _____

_____ your home with a babysitter at what age? _____

_____ a parent/child play group at what age? _____

_____ other settings:

How does your child adjust to new situations and activities?

Who is your child's current caretaker during the day?

How often does your child need to be held during the day?

How long can your child amuse him/herself?

How does your child communicate? (crying, pointing, phrases, sentences):

Can others understand your child's method of communication?

Is your child afraid of: _____ strangers _____ new situations _____ animals

List any other fears:

Your child's favorite toys and activities:

How does your child react to sharing his/her toys?

How does your child express anger?

How do you and your family spend time together?

SPECIAL MEDICAL CONSIDERATIONS
Please list any:

Does your child have any distinguishing birthmarks?

PARENTS' EXPECTATIONS

What are your goals and expectations for your child at Fontanelle Academy?

Do you have any special concerns or questions to which you would like to draw our attention?

How would you like to participate in our program?

_____ share a special skill/interest: _____

_____ assist with classroom activities: _____

_____ join us for special events: _____

_____ other: _____

_____ _____

Signature of Parent or legal guardian Date

Academic year: _____