Child’s Name: ____________________________ Date: __________ 

The following forms should be in this file:

___ Division of Licensing Form
___ Confidential Form
___ Commonwealth of Virginia School Entrance Health Form
___ Permission Form I
___ Permission Form II
___ Field Trip Permission Form
___ Extremely Important Information about My Child
___ Swimming Permission Form
___ Parent Agreement Form
___ Medical History and Consent Form
___ Past Enrollment
___ Discipline Form
___ Health Insurance Form
___ Arrival/Dismissal Form
___ Illness Notification Form
___ Authorization to Give Medication (If Applicable)

Enrollment Date: ___________________

Unenrollment Date: _________________
# Child Registration Form (Model)

<table>
<thead>
<tr>
<th>Child</th>
<th>Nickname</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed**

<table>
<thead>
<tr>
<th>Previous Child Day Care Programs and Schools Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Child Attends this Center and Another School/Program, Give Name of School/Program</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PARENT(S)/GUARDIAN(S)**

<table>
<thead>
<tr>
<th>Father</th>
<th>Place Employed</th>
<th>Business Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother</th>
<th>Place Employed</th>
<th>Business Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person(s) or Agency Having Legal Custody of Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business Address</th>
<th>Business Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY INFORMATION**

<table>
<thead>
<tr>
<th>Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Physician</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Two People To Contact if Parent(s) Cannot Be Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Address</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| 2. Address | Phone |
|           |       |

| 2. Address | Phone |
|           |       |

<table>
<thead>
<tr>
<th>Person(s) Authorized To Pick Up Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person(s) NOT Authorized To Pick Up Child*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_________________________________________________________________ ______________________
Parent(s) or Guardian(s) Date

_________________________________________________________________ ______________________
Administrator of Center Date

Date Child Entered Care: ____________________ Date Left Care: ____________________

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

OFFICE USE ONLY
IDENTITY VERIFICATION

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

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Birth Date</th>
<th>Birth Certificate Number</th>
<th>Date Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Form of Proof</td>
<td>Date Documentation Viewed</td>
<td>Person Viewing Documentation</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

032-05-252/11 (06/05)
CONFIDENTIAL CHILD INFORMATION

Child’s Name: __________________________________________
Address: _______________________________________________
City: ________________________ State: _________ Zip: __________

Parent 1 Name: __________________________________________
Parent 1 Address: _________________________________________
City: ________________________ State: _________ Zip: __________
Parent 1 Phone #: ____________________ Cellular #: __________

Parent 2 Name: __________________________________________
Parent 2 Address: _________________________________________
City: ________________________ State: _________ Zip: __________
Parent 2 Phone #: ____________________ Cellular #: __________

Child’s Physician: _________________________________________
Physician’s Address: _______________________________________
City: ________________________ State: _________ Zip: __________
Physician’s Phone #: ____________________

FORMS MUST BE SIGNED & DATED
PLEASE COMPLETE BOTH SIDES
PERSONS TO BE NOTIFIED IN CASE OF ILLNESS OR ACCIDENT OTHER THAN PARENTS:

Name: ______________________________________________________

Phone #: ___________________________ Cellular #: _______________________
Address: __________________________________ Relationship________________

City: ___________________ State: _______ Zip: ___________

Name: ______________________________________________________

Phone #: ___________________________ Cellular #: _______________________
Address: __________________________________ Relationship________________

City: ___________________ State: _______ Zip: ___________

Name: ______________________________________________________

Phone #: ___________________________ Cellular #: _______________________
Address: __________________________________ Relationship________________

City: ___________________ State: _______ Zip: ___________

LIST ALL ALLERGIES:
1. _____________________
2. _____________________
3. _____________________
4. _____________________
5. _____________________

LIST ALL MEDICAL CONDITIONS
1. _____________________
2. _____________________
3. _____________________
4. _____________________
5. _____________________

PERSONS AUTHORIZED TO PICK UP CHILD OTHER THAN PARENTS
(Under NO CIRCUMSTANCES will a child be released to anyone without authorization from parents):

Name: ____________________
Address: __________________
Phone #: __________________
Relationship: ________________

Name: ____________________
Address: __________________
Phone #: __________________
Relationship: ________________

Name: ____________________
Address: __________________
Phone #: __________________
Relationship: ________________
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 Name: ___________________  First Name: ________________  Middle Name: ___________________

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

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Date of Last Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrician/primary care provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Worker (if applicable)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: _____/______/______

MCH 213G reviewed 03/2014
### 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.

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
<th>RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Diphtheria, Tetanus, Pertussis (DTP, DTaP)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Tdap booster (6th grade entry)</td>
<td>1</td>
</tr>
<tr>
<td>*Poliomyelitis (IPV, OPV)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*Haemophilus influenzae Type b (Hib conjugate)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*only for children &lt;60 months of age</td>
<td></td>
</tr>
<tr>
<td>*Pneumococcal (PCV conjugate)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*only for children &lt;60 months of age</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR vaccine)</td>
<td>1 2</td>
</tr>
<tr>
<td>*Measles (Rubeola)</td>
<td>1 2</td>
</tr>
<tr>
<td>*Rubella</td>
<td>1</td>
</tr>
<tr>
<td>*Mumps</td>
<td>1 2</td>
</tr>
<tr>
<td>*Hepatitis B Vaccine (HBV)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>❑ Merck adult formulation used</td>
<td></td>
</tr>
<tr>
<td>*Varicella Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Meningococcal Vaccine</td>
<td>1</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

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

Signature of Medical Provider or Health Department Official: __________________________ Date (Mo., Day, Yr.): __/__/____
Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student’s health. The vaccine(s) is (are) specifically contraindicated because (please specify):

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

DTP/DTaP/Td[
]; OPV/IPV[
]; Hib[
]; Pneum[
]; Measles[
]; Rubella[
]; Mumps[
]; HBV[
]; Varicella[
]

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

Signature of Medical Provider or Health Department Official: __________________________ Date (Mo., Day, Yr.): |

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

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

Signature of Medical Provider or Health Department Official: __________________________ Date (Mo., Day, Yr.): |

Section III
Requirements

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

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

Certification of Immunization 03/2014
### 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](http://www.vahealth.org/schoolhealth).

#### Student’s Name: ____________________________ Date of Birth: _____/_____/______ Sex:  □ M  □ F

#### Health Assessment

<table>
<thead>
<tr>
<th>Date of Assessment: <em><strong><strong>/</strong></strong></em>/______</th>
<th>Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: ______ lbs. Height: ______ ft. ______ in.</td>
<td>1 = Within normal  2 = Abnormal finding  3 = Referred for evaluation or treatment</td>
</tr>
<tr>
<td>Body Mass Index (BMI): ______</td>
<td>1  2  3</td>
</tr>
<tr>
<td>Age / gender appropriate history completed</td>
<td>1  2  3</td>
</tr>
<tr>
<td>Anticipatory guidance provided</td>
<td>1  2  3</td>
</tr>
</tbody>
</table>

#### 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/IGRA Result: □ Positive □ Negative
- CXR required if positive test for TB infection or TB symptoms. CXR Date: __________ □ Normal □ Abnormal

#### EPSDT Screens

- □ Risked for Head Start – include specific results and date:
- Blood Lead: __________________________________________
- Hct/Hgb: __________________________________________
- EPSDT Screens: □ Required
- □ Recommended for Head Start – include specific results and date:

#### Developmental Screen

<table>
<thead>
<tr>
<th>Assessed for:</th>
<th>Assessment Method:</th>
<th>Within normal</th>
<th>Concern identified:</th>
<th>Referred for Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional/Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language/Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Motor Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Hearing Screen

- □ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.
- □ 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'/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

### 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: ___________________
- □ 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: ___________________

### Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

- Other Comments: ___________________

### Health Care Professional’s Certification

(name to be 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: ____________________________
For school age children:

I hereby grant permission for my child________________________________________ to ride in the bus/van provided by the Weinstein JCC to participate in the afternoon programs.

My child will be picked up from_________________________________________ school at __________ P.M.

I understand that I will be notified when my child becomes ill and that I will make every effort to pick him/her up as soon as possible.

I hereby grant permission for the Kids’ Place Director to take whatever steps necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

- Attempt to contact parent or guardian.
- Attempt to contact child’s physician.
- Attempt to contact parent through emergency numbers.

_____________________________________ ______________________
Signature of Parent or Legal Guardian   Date
PERMISSION FORM II

__ I Do __ I Do Not  authorize the Weinstein JCC of to release my address and phone number to other parents whose child(ren) is affiliated with this program.

__ I Do __ I Do Not  authorize the Weinstein JCC to apply sunscreen and insect repellent (lotion only) on my child’s skin. *Sunscreens and insect repellent must be sent in by parent and labeled with child’s name on it.*

__ I Do __ I Do Not  authorize the Weinstein JCC to use my child(ren)’s picture for the purposes of publicity and advertisement.

_________________________________  ____________________
Signature of Parent/Legal Guardian   Date
FIELD TRIP PERMISSION FORM

For school age children:

I hereby grant permission for my child________________________________________
to ride in the bus/van to participate in the following Kids’ Place programs:

(Please check for each program your child DOES have permission to participate in)

• Kids’ Place School’s Out Days
• Kids’ Place Winter Break
• Kids’ Place Spring Break
• Kids’ Break Camp

_____________________________________ ______________________
Signature of Parent or Legal Guardian   Date
EXTREMELY IMPORTANT INFORMATION ABOUT MY CHILD

Child’s Name: __________________________________________________________

Food/Insect/Contact Allergies: __________________________________________

_____________________________________________________________________

 Unless you direct otherwise in a writing delivered to the after-school, your child's name and allergy-related information will be posted on a list in each classroom, in the kitchen, art room and other areas used by our children, and in the after-school offices. We believe the posted allergy list serves as a visual reminder to all who interact with your child throughout the day.

Medical conditions the teacher should be aware of: __________________________

_____________________________________________________________________

_____________________________________________________________________

People authorized to pick up my child: ______________________________________

_____________________________________________________________________

_____________________________________________________________________

People who MAY NEVER pick up my child: ________________________________

_____________________________________________________________________

_____________________________________________________________________

Is there any other information you would like to share about your family structure, preferred child rearing practices, or your family’s background (such as socio-economic, linguistic, racial, religious and cultural background) that will help us to better serve your child and family?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________  ___________________
Parent’s Signature       Date
Swimming Permission Form

This form is due to Kids' Place office before your child(ren) is permitted to swim.

REMEMBER TO SEND THE FOLLOWING ITEMS EACH SWIM DAY!
Label Each Item with your Child’s Name!
• Bathing Suit
• Towel
• Bathing Cap or Ear Plugs, if needed (Long hair must be in a pony tail.)
• Swim Shoes, sandals, or flip flops
• Place all Items in a Labeled Plastic Bag
• An extra shirt to put on when getting out of the pool, to help keep warm

Permission Form: Please fill out and return in your child’s back pack or by fax to (804)285-3139

My child, ________________________________________________ (please print),
has my permission to swim and wade at the Weinstein JCC with the Counselors and Pool Staff.

Please rate your Child’s Swimming level: [ ] Beginner [ ] Intermediate [ ] Advanced

Comments: __________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Date    ______________________________
Parent’s Signature  ______________________________
Child’s Grade  ______________________________
PARENT AGREEMENT – MEDICAL TREATMENT

Name of Child: ________________________________________________________________

Dates of Attendance: ___________________________________________________________

Name of Child’s Physician: _________________________________________________________

Physician’s Address: _____________________________________________________________

Physician’s Phone: _______________________________________________________________

Child’s Home Phone Number: ______________________________________________________

Parent’s Work Phone Number(s): ___________________________________________________

Emergency contacts if your child becomes ill during the time he/she is at the JCC, and neither parent can be reached:

______________________________________________________________________________
Name    Address     Phone
______________________________________________________________________________
Name    Address     Phone

Should my child, ________________________________________________________________, become ill or suffer an accident of any character while he or she is in the care of the after-school program or classes, the Center shall undertake to contact me immediately. In the event the Center is unable to reach me immediately, the Center and/or its designated employee(s) shall be authorized to secure and consent to medical attention, treatment, and services for my child as may be deemed necessary.

Any qualified person providing such required medical attention, treatment, or services may accept consent as if given by me in person. I agree to assume responsibility for payment of all medical costs incurred.

______________________________  __________________
Parent’s Signature       Date
Child’s Name: _____________________________________

Kids’ Place Medical Form 2020-2021

MEDICAL HISTORY & CONSENT TO TREAT

***Please attach a copy of the child’s immunization records to this medical form upon completion of Kids’ Place forms/ medical form

***This form is valid for 14 months from the date of the physician’s signature

Health History: If “yes,” please fill in the applicable date.

<table>
<thead>
<tr>
<th>Health History</th>
<th>Date</th>
<th>Date</th>
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<tbody>
<tr>
<td>ADD/ADHD</td>
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<tr>
<td>Asthma</td>
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<td>Bedwetting/bladder/bowel problems</td>
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<tr>
<td>Bipolar Disease</td>
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<td>Cancer</td>
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<tr>
<td>Chicken Pox</td>
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<td>Dental</td>
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<td>Depression</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Kidney Disease</td>
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<td>Lyme Disease</td>
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<td>OCD</td>
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<tr>
<td>Recurrent Respiratory Ailments</td>
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<tr>
<td>Allergies (seasonal or food)</td>
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</tbody>
</table>

Other physical/mental health issues the camp should know:
______________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

If yes to any of the above, please describe in greater detail (attach a page if necessary):
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

Does your child take any prescribed medication? ( ) Yes ( ) No     Name of medication: ____________________________
Dosage: ____________________________________________________________
________________________________________________________________________________________________________________________________
List all over the counter, and herbal medications your child takes regularly:
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

Has your child had any major illnesses, operations, or significant injury (concussions, fractures) in the past which might, even remotely, bear on health needs at camp (other than noted above)?
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

Has your child been hospitalized or have they received outpatient treatment in the past year?  Yes  No
If yes, please explain: __________________________________________________________
________________________________________________________________________________________________________________________________

CONSENT TO TREAT

Should my child become ill or suffer an accident of any character while at Kids’ Place, Kids’ Place shall attempt to contact the parent/ emergency contact immediately. In the event of an emergency, Kids’ Place and/or its designated employee/s shall be authorized to secure and consent to such medical attention, treatment, and services for the child as deemed necessary.

Parent/Legal Guardian Signature      Date
PAST ENROLLMENT

Please provide the names of all childcare programs and schools your child has attended, including city and state, prior to attending the Weinstein JCC Kids’ Place.

<table>
<thead>
<tr>
<th>Name of Facility/School</th>
<th>City/State</th>
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DISCIPLINE

In keeping with the licensing requirements of April 1, 1986, this policy on discipline is to be signed by parents and Director and kept on file.

Staff encourages developmentally approved independence in children by using positive techniques of guidance, including redirection, anticipation and elimination of potential problems, positive reinforcement and encouragement rather than comparison or criticism. Staff abstains from corporal punishment or other humiliating or frightening discipline techniques. Persistent refusal to cooperate in cases of biting and inflicting bodily harm to other children results in the use of “rest time.” Consistent, clear rules are explained to children and understood by the adults.

_______________________________________________  ___________________
Parent’s Signature       Date

CHILD ABUSE AND NEGLECT

In accordance with State Licensing requirements, we are obligated to inform you that any suspected child abuse and/or neglect will be reported to Child Protective Services as required by §63.1-248.3 of the Code of Virginia.

_______________________________________________  ___________________
Parent’s Signature       Date
HEALTH INSURANCE FORM

State of Virginia, Licensing Department of Social Services, Health Standard 5.A.1 requires that each child’s health record includes specific information relating to the child’s health care insurance. Please complete the form below and return to Kids’ Place.

Check Only One Box

☐ My child is insured under the following health care policy:

   Insurance Carrier: _________________________________

   Policy No. _________________ Name of Primary Insured: ________________________

☐ My child is not insured.

☐ I decline to provide this information.

_______________________________________________
Child’s Name

___________________________________
Parent’s Signature

_______
Date
Arrival/Dismissal

For After-School Programs:

- If your child does not get on the bus/van from school, the bus/van driver will check with the school as well as the Weinstein JCC Kids’ Place program staff by phone.
- The Weinstein JCC staff would then call the parent to find out where the child is.
- It is noted in their file.
- Attendance is recorded as child get on and off the bus/van.
- Attendance is taken again once the child gets to their classroom.
- Each child is initialed-out as they are picked up by parent/guardian.

Late Fee and NO Call Fee:

If we have not received a call from you changing your child’s pick up for the day, there will be a $5.00 charge. Our van/bus drivers will call the Kids’ Place staff office when a child is not there for pick up.

Children must be picked up by their parent/legal guardian by 6:00 PM. If you know that you will arrive late for pick-up, you must contact LaVenus Harried (545.8639) or Zach Marson (545-8630) as soon as possible.

We request that all parents establish some form of emergency back-up procedure so that this policy need not be enforced. We will be happy to assist you in developing a back-up procedure that is comfortable for you and your child(ren). Please note that a waiver of this fee will only be granted in extreme emergency situations and is at the discretion of the Kids’ Place Director only.

________________________________________
Parent/Guardian Signature + Date
Illness Notification Form

I understand that I will be notified when my child becomes ill and that I will make every effort to pick him/her up as soon as possible. I understand that my child may not attend Kids’ Place until 24 hours of being free of a temperature over 101 F, recurrent vomiting or diarrhea, or a communicable disease.

I understand that I will be notified within 24 hours (or the next business day) of the Center having been informed of an incidence of a communicable disease among the Kids’ Place children.

I understand that I will inform the Weinstein JCC Kids’ Place within 24 hours or the next business day after my child or any member of my immediate household has developed any reportable communicable disease.

I hereby grant permission for the Director to take whatever steps necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

- Attempt to contact parent through emergency contacts.
- Attempt to contact parent or guardian.
- Attempt to contact child’s physician.

_____________________________  ______________________
Parent/Guardian Signature     Date
**Medication Authorization Form**

For Prescription and Non-preservation 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)*

____________________________________ has my permission to administer the following medication:  
*(Name of Child Care Provider)*

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: __________________________

032-05-0570-05-eng (06/12)  
Physicians Phone: __________________________