# INSTRUCTION SHEET FOR ENROLLMENT APPLICATION

## RESURRECTION LUTHERAN SCHOOL AND CHILD CARE

- This sheet is to help you fill out the necessary forms required to enroll your child in our program. When all the forms are complete, please return it to the School Office.

**CHILD'S NAME**
Use the legal name that corresponds with your child's birth certificate.

**BIRTH DATE**
Proof of birth date is required. Please present your child's birth certificate to the School Administrator at the time of enrollment. The School Administrator will verify the birth date and return the certificate to you.

**MEDICAL FORM**
Please complete the four page form, ***Commonwealth of Virginia School Entrance Health Form – Part I: Certification of Immunization - Form, Part II: and Comprehensive Physical Examination Report - Part III:***

**RELEASE FORM**
Indicate on this form the names of people to whom our staff can release your child. Also, indicate any people to whom we CANNOT release your child. *****Be sure that the three people listed as your Emergency Contacts are also listed on your child's Release Form.***

**EMERGENCY CARE AND CONTACTS FORM**
List at least three people we can contact in an emergency if we are unable to contact your child's parent/guardian. *****Be sure that the three people listed as your Emergency Contacts are also listed on your child's Release Form.***

**PARENT RELEASE FORM FOR MEDIA RECORDING**
Please indicate on this form whether you grant permission or not for your child's image to be used as indicated, but not limited to, on the release.

→ **DOUBLE CHECK**

Did you include?
- Enrollment Form
- Medical Form (all three parts complete)
- Child Release Form
- Emergency Care and Contacts Form
- Parent Release for Media Recording

→ **SIGNATURES** →

- Enrollment Form
- Medical Form
- Child Release Form
- Emergency Care and Contacts Form

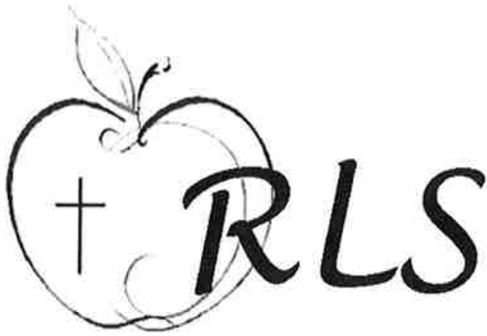
**THEN BRING**

- **all your forms,**
- **$100.00 registration (returning) or $125.00 for new registration fee**
- **AND your *child's Birth Certificate***

to the School Office to complete the enrollment process. **Your child is not officially enrolled until all the necessary items listed on this sheet are complete.**

**IF YOU HAVE ANY QUESTIONS**
**PLEASE CALL**
**the SCHOOL OFFICE**
**(757) 596-5808**

***June 2018***




ENROLLMENT FORM

2019-2020

| DOE | DOW |
|---|---|

# Resurrection Lutheran School and Child Care

- **Section 1: Child Information**

Child's Name: ______________________________ / ______________
Last Name First Name MI Preferred Nickname

Date of Birth: ____________________ Gender ____M ____F

Home Address: ______________________________________
Street

______________________________________
City State Zip Code

Child's Home Telephone Number: ______________________________

- **Section 2: Family Information**

Parent/Guardian Name: ______________________________
First Name MI Last Name

Occupation and place of employment: ______________________________

______________________________________________________

Telephone: ______________ / ______________ / ______________
Home Work Cell

**Email address**: ______________________________

Parent/Guardian Name: ______________________________
First Name MI Last Name

Occupation and place of employment: ______________________________

______________________________________________________

Telephone: ______________ / ______________ / ______________
Home Work Cell

**Email address**: ______________________________

## ENROLLMENT FORM

**Immediate Family Members:**

| Name: | Relationship to Child | Living with child? Yes | No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

If there are additional family members, please list them on a separate sheet of paper.

Family Church: ____________________________________________

- **Section 3: Child's Personal History**

Has your child had a previous school or child care experience? __________ Yes __________ No

If yes where and when? ____________________________________________

____________________________________________

Does your child have any allergies? __________ Yes __________ No

If yes, please describe/list:

____________________________________________

____________________________________________

Are there any medical problems the child care staff needs to be made aware of?

____________________________________________

____________________________________________

What words does your child use for toileting? ______________________________

Does your child have any bowel or bladder irregularities? __________ Yes __________ No

If yes, please describe:

____________________________________________

____________________________________________

# ENROLLMENT FORM

Are there any special food or meal instructions? __________ Yes __________ No

If yes, please describe:

______________________________________________________________________

______________________________________________________________________

Are there any special sleeping/napping instructions? __________ Yes __________ No

If yes, please describe: ______________________________________________

______________________________________________________________________

What is your child's concept of God? __________________________________

______________________________________________________________________

**Please include any additional information such as special accommodations needed, discipline, communication, comforting, etc. that will assist our staff in caring for your child**:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Drop off Time: __________________ Who will usually drop off your child? __________________

Pick up Time: __________________ Who will usually pick up your child? __________________

**THE FINANCIAL AGREEMENT FORM ON THE BACK MUST BE COMPLETED AND SIGNED. A NEW AGREEMENT WILL NEED TO BE COMPLETED, IF ANY OF THE FINANCIAL DATA CHANGES.**

| FOR OFFICE USE ONLY | | | |
|---|---|---|---|
| **Birth Date** | **Birth Certificate** | | **Verified by:** |
| | **State** | **Number** | |
| | | | |

# ENROLLMENT FORM

## Resurrection Lutheran School and Child Care

Enrollment Worksheet & Financial Agreement for All Students
**Legal and binding contract between Parents/Guardian and RLS**

**Registration Fee (Non-refundable): $________ Date paid: ________________**

Program enrolled: ____________________________________________________
Child's name Program

Annual Tuition: $___________ Monthly Tuition: $______________

| Attending Childcare: | Yes | No | Before Care | After Care | Both | Monthly Fee: |
|---|---|---|---|---|---|---|
| | | | _________ | ________ | ____ | $__________ |

Other fees: T-shirt size: **YXS YS YM YL** $12

**Payment Plan: (circle one)** 10 month (1st of the month) 12 month (1st of the month) or Pay in Full

Receive a 10% discount on tuition when tuition is paid in full for the school year by September 1st
**** (POSTDATED CHECKS WILL NOT QUALIFTY FOR THE 10% DISCOUNT)**

**Amount Due for 2019-2020 School Year:**

**Other Fees (t-shirt):$ _______**

**Student Monthly Tuition Fees: $________**
**Before/After Child Care: $________**

**Total Monthly Fees Due: $______________**

## Financial Agreement

***I understand and agree to the following:***
**The Registration Fee is non-refundable.**

- No credit will be given for vacation taken during the school year.
- **PAYMENT IS DUE ON THE FIRST WORKDAY OF THE MONTH**
- The first month's tuition **must** be paid prior to my child(ren) entering the school and child care and is **non-refundable.**
- A $35 bookkeeping fee will be charged for returned checks.
- A $35 late fee will be assessed for payments received after the 5th of the month.
- If my monthly payment is not paid by the 20th of the month, I understand that my child(ren) may be suspended from school until my account is current.
- I understand that my account will be sent to a collection agency if I fail to pay all tuition & fees due the school. I understand that I am responsible for all reasonable legal and/or collection fees.
- No records will be released until payments are current and up-to-date.
- I have read and understand the financial policy as outlined in the RLS Handbook.

________________________ ________________________ __________
Parent/Guardian Printed Parent/Guardian Signature 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 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: ____/____/______

MCH 213G reviewed 03/2014

**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:** ______________________

# CHILD RELEASE FORM

## RESURRECTION LUTHERAN SCHOOL AND CHILD CARE

**Child's Name:** ____________________________________________

**Parent/Guardian:** ____________________________________________

We need the names of people to whom we can release your child. Also, we need the names of people to whom we can **NOT** release your child. Keep in mind that the people you authorize must be at least 18 years of age and able to show picture identification if asked to do so by the Resurrection Lutheran School and Child Care staff.

**I, ____________________________________________, authorize the staff of Resurrection Lutheran School and Child Care to release my child to:**

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

**Do NOT release my child to:**

____________________________________________

____________________________________________

**Parent/Guardian's Signature:**

____________________________________________

**Date:** ____________________________________________

**August, 2017**

**RESURRECTION LUTHERAN SCHOOL**
**AND CHILD CARE**

## PERMISSION FOR EMERGENCY TRANSPORT AND TREATMENT

**CHILD'S NAME:** ______________________________ **BIRTH DATE:** ____________
**ADDRESS:** ______________________________________________
**PARENT/GUARDIAN'S NAME:** ________________________________
**ADDRESS:** ______________________________________________

**IN CASE OF EMERGENCY:**
I give legal consent for my child to receive emergency transport and treatment from the Emergency Medical Services in the event that my child is injured while in the care of Resurrection Lutheran School and Child Care. Emergency Medical Services can take my child to the nearest hospital for the treatment and care of any injuries. I also give legal consent for the hospital staff to provide treatment and care of my child. I understand that I will be notified immediately at the number(s) listed below of any emergency and given instructions on where to go to be with my child.

I will be notified when my child becomes ill and I will arrange to have my child picked up as soon as possible if requested by RLS&CC.

I will inform the center within 24 hours or the next business day after my child or any member of my immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

______________________________________ ____________________
**Parent/Legal Guardian's Signature** **Date**

Parent/Guardian's Address (if different from above): ____________________________

Telephone: Work # ____________/Page/Cell # ______________ /Other # ____________

Physician's Name: __________________ Address: ______________________________

Telephone: Office # ____________________/Emergency # ________________________

Dentist's Name: ____________________ Address: ______________________________

Telephone: Office ____________________/Emergency # ________________________

**Other Emergency Contacts (*be sure these names are also listed on your child's Release Form*):**

1. Name: __________________________ Address: ____________________________

Relationship to Child: ____________ Telephone: Home # __________ / Other # __________

2. Name: __________________________ Address: ____________________________

Relationship to Child: ____________ Telephone: Home # __________ / Other # __________

3. Name: __________________________ Address: ____________________________

Relationship to Child: ____________ Telephone: Home # __________ / Other # __________

**August, 2017**