HOPE Preschool (Form 2)

Registration Agreement

We have reserved a place for your child, _____, for the school year beginning September 9, 2024. Enrollment is for the 2024 - 2025 school year, September - May.

Please read the following financial policies and procedures. Initial and sign where indicated to acknowledge receipt and understanding:

- **All Enrollment Forms must be on file by August 1, 2024.** Your child's physical must be performed no more than 12 months prior to the first day of the school year, September 9, 2024.
- Payment and Fee Policies:
  - The registration fee ($175) is non-refundable. ____initial
  - **Payments are due on the 1st of every month, starting August 1, 2024.** (**9 consecutive payments** – Aug. 1-April 1). A 10 day grace period is given before a $35 late fee is applied.
  - The first payment is due on August 1st, 2024 and pays for time & materials needed to prepare for the beginning of the school year. **Monthly payments are non-refundable and cannot be applied to future months' payment.** (Please refer to Page 2 for the Payment Schedule.) ____initial
  - A payment will be due on May 1st for all families whose first payment is made on or after September 1st.
  - HOPE Preschool must meet its financial obligations regardless of attendance of an individual child. Therefore, there will be no refunds for absences.
  - Any check or ACH payment returned for any reason, including user cancellation, insufficient funds, etc., will be charged a $35 bank fee.
  - We reserve the right to charge a tardiness fee per student for families who are habitually late at arrival or dismissal time. Late is defined as 15 minutes or more after class arrival or dismissal time. ____initial
  - All accounts must be paid up to date in order for a child to participate in any enrichment opportunities.
  - All accounts must be paid up to date in order to register a child (current student or sibling) for future school years.
  - Unpaid balances, including monthly payments, late fees, late pick-up fees, and returned check fees, must be paid within 30 days of assessment in order to avoid incurring additional late fees.
  - Your child may be removed from our program if payments are not made in a timely manner or if outstanding balances are not satisfied.
  - In the event of an unforeseen school closure, a decision regarding payments and/or refunds will be left up to the discretion of HOPE Preschool's Director.
- Families must fill out an Early Withdrawal Form (available in the office) 30 days in advance of withdrawing a child prior to the end of the school year. A $150 early withdrawal/administrative fee is due with the form to release you from your remaining monthly financial obligations. (Please refer to Page 3 for the Payment Schedule.)

I have read and agree with all of the above policies.

_____ _____

Signature of Financially Responsible Party Date

All children attending HOPE must be potty-trained and able to independently use the restroom by August 1st.

Children exhibiting the following symptoms must be kept at home: fever, pink eye, diarrhea, lice, or vomiting **in the previous 24 hour period**. If your child is sent home from school with any of these symptoms, they must remain out of school for at least one additional school day. In the case of fever, they must remain out of school until fever free for at least 24 hours without fever-reducing medication. Children too sick to participate in the full program, including outside play, need to be kept at home. **If a student tests positive for COVID-19, we **must** be notified so that we are able to follow the guidelines of the Loudoun County Health Department.*

Children who have **ANY** food allergies to **ANY** degree, or a dietary restriction requiring a special diet, are required to provide their own snack on a daily basis.

Children who have a doctor prescribed EpiPen Jr./Auvi-Q **MUST** have a current EpiPen Jr./Auvi-Q at school at all times while in attendance. Children participating in enrichment opportunities must provide a second current EpiPen Jr./Auvi-Q. Expiration dates will be closely monitored.

I have read and understood the above information.

_____ _____

Signature of Financially Responsible Party Date

(Form 2)

HOPE Preschool
2024– 2025 Payment Schedule

	PAYMENT DUE DATE	ATTENDANCE	EARLY WITHDRAWAL NOTIFICATION +$150 FEE PAYMENT	LAST PAYMENT AND LAST MONTH OF ATTENDANCE
1	August 1st	Conferences & Preparation for School Start		
2	September 1st	September	September	October
3	October 1st	October	October	November
4	November 1st	November	November	December
5	December 1st	December	December	January
6	January 1st	January	January	February
7	February 1st	February	February	March
8	March 1st	March	March	April
9	April 1st	April	April	May
	No Payment	May		

HOPE Preschool
43454 Crossroads Drive, Ashburn VA 20147
703-729-HOPE (4673)

ACH Recurring Payment Authorization Form (2024-25 School Year)

Schedule your payment to be automatically deducted from your checking or savings account.
****Please attach a VOIDED check to this form****

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking or savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected. For students starting school after September 1, 2024, payments will continue through May 1, 2025. Automatic draft payments will automatically cancel at the end of the school year.

Please complete the information below:

I _____ authorize HOPE Preschool to charge my bank account below on the 1st of
(full name)

each month, beginning _____ and continuing through _____, in the amount of

$_____.

Student's Name: _____ Class: _____

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Account Type: ☐ Checking ☐ Savings

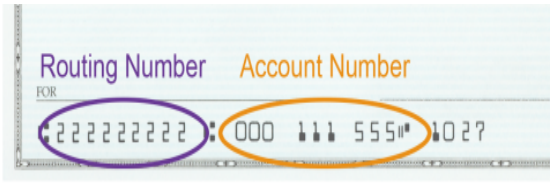
Name on Acct _____

Bank Name _____

Bank Routing # _____

Account # _____

Bank City/State _____



I understand that this authorization will remain in effect until canceled in writing and I agree to notify HOPE Preschool in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for ANY reason, (Non-Sufficient Funds (NSF), cancellation without notification), I understand that I will incur a $35 charge. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

Office Use Only:

# of Occurrences: _____
Beginning Month: _____ through Ending Month: _____
Date Entered into System: _____ Date Deleted: _____ Revised 5/2024

HOPE Preschool

Child/Family Personal History

The purpose of collecting this information about your child is to help the HOPE Preschool staff better understand your child and thus support and encourage their success in preschool. All information is kept confidential and requires your written permission before being shared. Some questions may not be applicable to your child at this time; please leave them blank.

FAMILY INFORMATION Date _____

Child's Name _____ Known as _____
(Name you wish your child to write and identify)

Sex _____ Age _____ Date of Birth _____

Address _____

_____

How long have you lived in this city? _____

Mother (guardian) _____ Occupation _____

Employer name & address _____

Father (guardian) _____ Occupation _____

Employer name & address: _____

Marital Status: Married _____ Divorced _____ How long? _____

Single Parent _____ Separated _____

Custody/visiting arrangements _____

Siblings: Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Other members of the household (include relationship and age) _____

_____

Is English your child's primary language? _____

Do you speak a language at home other than English? _____ If so, what? _____

Are there special words that would help us communicate with your child? _____

_____

Are there any cultural practices or holidays you would like us to know about? _____

_____

What age was your child when he/she first separated from Mom and/or Dad? (i.e. illness, hospitalization, babysitter, school, daycare, etc.) _____

Explain _____

Attended HOPE Preschool 2023 - 24? Yes No Class Name:_____

DEVELOPMENTAL MILESTONES

Type of birth Full Term _____ Premature _____

Any complications? _____

Age your child began sitting _____ crawling _____ walking _____

Is your child a good climber? _____ Does he/she fall easily? _____

Age your child began talking _____Does your child speak in words? _____ or sentences? _____

Does your child have any speech delays or challenges? _____

SLEEPING HABITS

What time does your child go to bed? _____ Awaken? _____

Is your child ready for sleep? _____ Does he/she have his/her own room? _____ Own bed? _____

Does your child walk, talk, or cry out in their sleep? _____

What item does your child take to bed with him/her? _____

Does your child take naps? ____ what time/how long?_____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child had experience playing with other children? _____

By nature, is your child: Friendly _____ Aggressive _____ Shy _____ Withdrawn _____

How does your child get along with his/her brothers and sisters? _____

Other adults? _____

With what age child does he/she prefer to play? _____

Will your child know any children in the preschool? _____

What makes your child angry or upset? _____

_____

How does your child show his/her feelings? _____

_____

What discipline method(s) is used in your home? _____

_____

What is your child's usual reaction to discipline? _____

_____

Who does most of the disciplining? _____

Is your child frightened by any of the following: Animals _____ Tall people _____ Loud noises _____

Dark _____ Storms _____ Anything else? _____

Does your child have a pet? _____ Type _____ Name _____

How much time does your child spend using electronics each day?

TV _____ Computer_____ Video Games _____ IPad_____ Cell Phone _____

What are your child's favorite programs, games, etc.? _____

_____

Favorite toys and activities at home _____

_____

Does your child like to read or be read to? _____ Visit the library? _____ Listen to music? _____

Does your child enjoy playing outdoors? _____ Ride a tricycle or scooter? _____

Has your child had experience with: Play Dough _____ Scissors _____ Easel painting _____

Crayons/Markers_____ Finger painting _____ Blocks _____ Water play _____

What do you consider to be your child's strengths? _____

_____

What do you and your child enjoy doing together? _____

_____

Does your child have any difficulties that we should be aware of? _____

_____

HEALTH HISTORY

Does your child have a chronic illness or condition such as:

Asthma ____ Diabetes ____ Cystic Fibrosis ____ HIV ____ AIDS ____ Hepatitis B ____ Epilepsy ___

Seizures ___ ADHD ___ Autism Spectrum ____ Other_____

Explain _____

Does your child have frequent: Colds _____ Earaches _____ Stomachaches _____ Nosebleeds_____

Explain_____

Does your child vomit easily? ____ Explain _____

Does your child experience high fevers often? _____ Explain _____

Has your child had any serious injuries? _____ Explain _____

Does your child have *non-food* allergies? ____ Symptoms?_____

Does your child have any food allergies? _____ List Foods _____

Symptoms _____

Does your child have a doctor-prescribed EpiPen Jr. or AuviQ ? _____

Has your child ever been hospitalized? _____ Explain _____

Has your child ever had a vision test? _____ a hearing test? _____

Does your child wear corrective shoes? _____ Glasses?_____

Does your child have any special needs? _____ Explain _____

_____

Does your child eat with a spoon? ____ Fork? _____ What time does your child eat breakfast? _____

Is your child right or left-handed? _____ Is your family vegetarian? _____

Other dietary restrictions: _____

TOILET HABITS

(Please remember, due to our licensing requirements, your child must be able to independently use the bathroom.)

Can your child be relied upon to let the teacher know they need to use the bathroom? _____

What word is used for urination? _____ for bowel movement? _____

Does your child need to go more frequently than usual for his/her age? _____

Is your child frightened of the bathroom? (for example, flushing toilet?_____

Does your child have accidents? _____ How does he/she react to them? _____

Does your child need help with toileting (i.e. help with clothing, zippers, buttons)? _____

Was your child easy or difficult to toilet train? _____

Does he/she wet the bed at night? _____ How often? _____

OTHER

Briefly describe your child (personality, abilities, etc.) _____

_____

_____

_____

_____

_____

What are your expectations for your child at HOPE Preschool? In what particular ways can we help your child? _____

_____

_____

_____

_____

HOPE Preschool EMERGENCY INFORMATION

Name of Child: _____ Date of Birth: _____

Address:_____
(Street) (City) (State) (Zip Code)

Parent/Guardian Name: _____

_____
(First Call Primary Phone Number) (First Call Alternate Phone Number) (Relationship)

Parent/Guardian Name: _____

_____
(Second Call Primary Phone Number) (Second Call Alternate Phone Number) (Relationship)

LOCAL persons to call in case of an emergency when parents cannot be reached:

1._____
(Name) (Relationship) (Contact Phone Number)

2._____
(Name) (Relationship) (Contact Phone Number)

Additional person(s) **AUTHORIZED** to pick up child_____

_____

Person(s) **NOT AUTHORIZED** to pick up child_____

Is this a court order? _____ (If yes, please supply documentation and photo.)

HOPE Preschool MEDICAL RELEASE

In case of emergency at school , if neither parent can be reached and/or time is of the essence, we authorize the staff of HOPE Preschool to have our child,_____ , transported to the emergency room and further authorize the medical staff of the hospital to administer treatment considered necessary for the well being of our child. We will assume financial responsibility for the cost of the ambulance and/or for treatment administered at the hospital. I understand that my child will be transported to Inova Loudoun Hospital.

Medical information/allergies concerning our child which should be known to the hospital include:

_____

I understand that HOPE Preschool will contact the Poison Control Center and follow their instructions if needed.

Parent's Signature:_____ Date:_____

(Form 4)

MEDIA AUTHORIZATION

I give permission for my child's photo to be used on the HOPE Preschool website (including the electronic newsletter), the HOPE Preschool Facebook page, the Crossroads United Methodist Church website, and in local newspaper features or other social media outlets. I further understand that children will NOT be identified by name.

Child's Name: _____

_____ **YES**, my child's photo may be used

_____ **NO**, do not use my child's photo

Parent/Guardian Signature:_____Date:_____

I give permission for my child's photo to be shared on a private photo site (such as Shutterfly, Homeroom, SeeSaw) to be accessed only by my child's teachers, parents of other children in my child's class, and HOPE Preschool office staff. Teachers have the option of creating this photo site for their class. It is not required.

_____ **YES**, my child's photo may be used

_____ **NO**, do not use my child's photo

Parent/Guardian Signature:_____Date:_____

Revised 11/2023

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____ - _____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions

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

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

Box 2. Medications

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

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

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

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

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

I_____(do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

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

Signature of Interpreter: _____Date_____/_____/_____

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

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

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

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

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

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

Certification of Immunization

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

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):** 12 /___/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

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

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

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

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

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

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

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

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

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

Section III Requirements

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

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

Test for TB Infection: TST IGRA Date: TST Reading mm TST/IGRA Result: ☐ Negative ☐ Positive

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

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities

Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

____I**ndividualized 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:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

MAT

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe): _____

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:
Required for Long-Term medication or when dosage directions state "consult a physician".

This is a double-sided form

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name).

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility telephone number:	26. (leave blank)
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child._____
34. Licensed Authorized Prescriber's Signature:
35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE:_____ By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature:

This is a double-sided form