Attention Parents

We are required by the Commonwealth of Virginia to secure, before the child may attend, and maintain, while in our care, a current file containing specific information regarding the health and safety of your child.

Required Paperwork

- A completed application including start date, phone numbers and physical addresses of two local emergency contacts, physician's name and number, allergies, guardian's work information, and one guardian signature.
- Proof of shots and proof of physical signed and dated by a physician. As child receives new shots, a new record is required.
- A copy of the birth certificate or proof of birth letter from the hospital.

Your support in this matter is greatly appreciated.

Childcare Registration

Start Date_____ End Date_____

Selected Program_____ Member Number_____

Child's full name_____ Nickname

Address_____
Street address City State Zip Code

Phone number (H) _____ (C) _____ SEX_____ DOB_____

Previous day care or schools attended_____Grade_____

Child's Physician_____ Phone_____

Allergies_____

Physical/Developmental information_____

Please list any special accommodations_____

(It is the responsibility of the parents to inform the Director with updated information)

Mother's Name_____ Home Phone_____

Complete Address_____
Street address City State Zip Code

Place of Employment_____ Work Phone_____

Father's Name_____ Home Phone_____

Complete Address_____
Street address City State Zip Code

Place of Employment_____ Work Phone_____

People Authorized to Pick-Up Child_____

People NOT Authorized to Pick-Up Child_____
Appropriate paper work such as divorce decree must be attached if a parent is not allowed to pick up the child

Emergency Contacts (must have 2 physical addresses & phone other than parents)

Name_____ Phone_____

Complete Address_____
Street address City State Zip Code

Name_____ Phone_____

Complete Address_____
Street address City State Zip Code

Authorization for Emergency Medical Care

I authorize Boars Head Sports Club Staff to provide emergency medical care should an emergency occur when the parent cannot be located immediately. This is not required by state regulation if the parent states an objection to the provision of such care on religious or other grounds.

Objection_____

The Boar's Head child care staff has the right to exclude your child from the program if he has a temperature of 100 degrees F; if he has recurrent vomiting or diarrhea, or as recommended in the Virginia Department of Health's communicable disease chart. I understand that if my child becomes ill while in the care of Boar's Head staff, I will be notified and must make arrangements to have my child picked up immediately.

During participation in Child Care, classes and Summer Kids Club photographs which embody the spirit and nature of the programs at Boar's Head Sports Club are occasionally taken of participants. Your signature below authorizes Boar's Head Inn to print, publish, and display pictures or videos of you, other members of your family and the participant registered above in various publications, on the www.boarsheadinn.com web site and in the public media.

I further agree to inform the center within 24 hours or the next business day after the child or any member of the 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.

By signing below I have read and agree to all of the policies and procedures set forth by Boar's Head Sports Club for their Children's Programs. On behalf of myself and my child, I forever release and hold harmless Boar's Head Inn and Sports Club from any claim, suit, demand or cause of action resulting from any injury to my child during the time the child is in the care of staff, except such injury as may arise out of gross negligence or intentional misconduct.

Mother's signature_____ Date_____e-mail_____

Father's signature_____ Date _____e-mail_____

FOR OFFICE USE ONLY

Birth certificate information

Place of birth _____ birth date_____birth certificate #_____Other form of proof (notification of birth hospital, physician or midwife record) baptismal record, school record from a public school in VA, a certification from a principal that a certifies copy of birth certificate was previously presented).

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 Mother or Legal Guardian: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Father or Legal Guardian: _____ 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, etc.):

_____

_____

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

_____

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

Please provide the following information:

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

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

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

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

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

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

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

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

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
*Tdap booster (6th grade entry)	**1**				
*Poliomyelitis (IPV, OPV)	**1**	**2**	**3**	**4**	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
*Pneumococcal (PCV conjugate) *only for children <2 years 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* (Minimum requirements are listed in 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.)

Certification of Immunization 10/2010

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

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred
Mantoux results: _____mm

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	☐	☐	☐

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 ☐ epi pen ☐ 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)**:**

Name : _____ **Signature:** _____ Date: ____/_____/_____

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

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