Auburn Baptist Preschool

AUBURN BAPTIST CHRISTIAN ACADEMY

PO Box 917 ~ 3840 Riner Road ~ Riner VA 24149

~ 540-382-8824 ~ mking@auburnbaptist.com

We are excited to open our enrollment for the 2020-2021 school year. Auburn Baptist Preschool strives to offer a Christian based preschool program that will help your child grow in all areas of his/her life. In addition to teaching basic preschool skills, we want to instill a Biblical foundation by sharing Bible stories, songs, verses, and Bible truths on a daily basis. More information on A BEKA Book may be viewed at **http://www.abeka.com/**.

Auburn Baptist Preschool offers two, three, and five day preschool programs. Children must be three years old on or before the last day of September of the current year to enroll in the three-year-old program and four years old by the last day of September of the current year to enroll in the four-year-old program. ALL children must be completely potty trained before entering preschool. Days, times, and prices are listed below. All classes are held from 8:30am to 3:05pm on each given day.

K4 Junior Kindergarten offers a traditional kindergarten classroom experience with a structured environment to help children move forward with the A BEKA Book curriculum. If you should be interested in K4 Junior Kindergarten, please contact us for additional enrollment information and forms.

If you would like to enroll your child in Auburn Baptist Preschool or ABCA K4 for the upcoming school year, please contact us for enrollment forms. A copy of your child's birth certificate and a completed health/immunization form signed by your child's physician must be included with the enrollment form and received two weeks prior to the opening day of preschool.

Once we receive your enrollment form and fees, we will send you more information on open house and the exact start date of the school year. Thank you again for your interest. We look forward to working with you and your child.

A fee of $200 must be paid in order to hold your child's spot for the upcoming school year. If you decide not to have your child attend ABCA, the fee is nonrefundable. However, if your child does attend ABCA, the fee will be applied towards your total tuition.

Circle your choice:

Two Day Program (Tues & Thurs) 8:30am-3:05am.....$2,600 tuition

Three Day program (Mon Wed & Fri) 8:30am-3:05pm.....$3,400 tuition

Five Day (3yr old) Program 8:30am-3:05pm .....$4,600 tuition

Jr. K4 – Five Day (4yr old) Program 8:30am-3:05pm.....$4,600 tuition

Auburn Baptist Preschool

Enrollment Application for School Year: _____

Policies:

~All students must be completely potty trained prior to first day of school.
~A 30-day written notice is required prior to withdrawal.

Class Requested:

3-year-old Two Day Program (T&Th) ____

3-year-old Three Day Program (MWF) ____

Five Day (3yr old) Program _____

Jr. K4 (4yr old) Program (Mon. – Fri.)_____

Tuition is due on the 20th of each month.

Today's Date: _____

Student's Full Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: M / F Home Phone: _____

Mailing Address: _____Zip: _____

Physical Address: _____Zip: _____

Mother's Name: _____ Father's Name: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Email: _____ Email: _____

Emergency Contacts: *Please note that emergency contacts must be local and available to pick up your child in the event that you cannot be reached.*

1. Name: _____Relationship to Student: _____
   Address: _____ Zip: _____
   Home #: _____ Cell #: _____ Work #: _____
2. Name: _____Relationship to Student: _____
   Address: _____ Zip: _____
   Home #: _____ Cell #: _____ Work #: _____
3. Name: _____Relationship to Student: _____
   Address: _____ Zip: _____
   Home #: _____ Cell #: _____ Work #: _____

*Please list all individuals that have been given permission to pick up your child. Be aware that ANYONE picking up your child must show a valid photo ID.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Additional Information

Has student ever made a profession of faith in Christ? _____

Have student's parents ever made a profession of faith in Christ?

Mother: _____ Father: _____

Do you consider your home a Christian home? _____

What church does your family attend? _____

Are you a member of the church? _____

Which of the following most accurately describes your family's church attendance.

____ a. Active in the church ____ c. Children attend church

____ b. Attend Occasionally ____ d. Attend a few times a year

Explain briefly why you desire a Christian education for your child.

_____

_____

_____

Do you have other school age children that you will NOT be enrolling at Auburn Baptist Christian Preschool? _____

If yes, please explain why. _____

_____

_____

_____

How did you hear about Auburn Baptist Christian Academy/Preschool?

_____

Has your child ever attended preschool or any other form of a childcare setting? Y/N

_____

If yes, please list: _____

_____

What types of activities does your child enjoy? _____

_____

Please list siblings and ages:

1. Name: _____ Age: _____
2. Name: _____ Age: _____
3. Name: _____ Age: _____

Please list pets and names:

1. Name: _____ Type: _____
2. Name: _____ Type: _____

Tell us any additional information that you would like us to know about your child or that may be helpful to us: _____

_____

Medical Information

**Health/Immunization form required before the start date of school.*

Allergies: _____

Any other medical issues: _____

Physician's Name: _____ Phone #: _____

TERMS AND CONDITIONS

a. Auburn Baptist Christian Academy/Preschool reserves the right to accept or reject any application.

b. Auburn Baptist Christian Academy/Preschool admits students of any race, color, or national and ethnic origin to all rights, privileges, programs and activities generally accorded or made available to students of the school.

c. School policies are subject to change. Information on current policies will be made available at parent orientation meetings prior to enrollment.

d. Applicants agree to abide by all school policies, rules and regulations, including provisions for dress codes and discipline. Auburn Baptist Christian Academy/Preschool has full discretion in the discipline of students while at the school.

e. Applicants agree that their students will receive instruction in the Christian Faith and understand that the school will endeavor to be guided by a Christian worldview in all of its programs and activities.

f. Auburn Baptist Christian Academy/Preschool provides priority enrollment for children of Auburn Baptist Church members and children with enrolled siblings. Space must be available, and the enrollment request must be exercised within the priority enrollment period. Information about priority enrollment may be obtained by contacting the office.

g. The school has policies designed to meet a reasonable standard of care for students who become ill or have an emergency situation at school. Parents are required to sign a medical release form each year allowing emergency medical care to be obtained in the case parents cannot be reached.

h. The school's Schedule of Fees provides information about financial terms and obligations. It is updated annually. Students are enrolled for the entire year and

the parent or guardian is responsible for the annual tuition payment upon accepting enrollment. A non-refundable $200.00 enrollment fee must be submitted with this Student Application Form.

i. Auburn Baptist Christian Academy/Preschool is a ministry of Auburn Baptist Church and is governed by a board made up of: Pastors, School Administration and Deacons of Auburn Baptist Church.

I hereby certify that I have read this Student Application Form, including the Terms and Conditions Section. I do agree to comply with the terms and conditions stated therein and furthermore accept the conditions and requirements of all other official policies and procedures of Auburn Baptist Christian Academy/Preschool, including the payment of all fees and charges according to the published schedule of the school.

This application cannot be processed until the registration fee is paid in full and the application is signed by the parents or guardian of the applicant. We also require a copy of the birth certificate for each child as well as shot records before the application can be processed.

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____

Date Complete Application & Deposit Received: _____

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*Office Use Only

Enrollment Fee Paid ($200): _____Date: _____ Cash: _____ Check #: _____

Enrollment Form Complete: _____

Health/Immunization Form Received: _____ Date: _____

Copy of Birth Certificate Received: _____ Date: _____

3-Year-Old Two Day Prog. (T&Th) _____ 3-Year-Old Three Day Prog. (MWF) _____

Five Day (3yr old) Program _____ Jr. K4 Program (Mon. – Fri.) _____

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
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 [illegible] 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.*):** ___/___/___

Certification of Immunization 11/06

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

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: _____

PERMISSION FOR MEDICAL TREATMENT

Student's Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____ Zip Code: _____

Father's Name: _____ Employer: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Mother's Name: _____ Employer: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Student's Current Medications: _____

Significant Medical Issues: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I, the undersigned, do hereby affirm and represent that I am the parent or legal guardian of the aforementioned student.

On behalf of the student mentioned above, I hereby consent and authorize Auburn Baptist Christian Academy to provide reasonable and necessary medical treatment in the event that we cannot be reached.

This authorization and consent shall remain in effect until it is otherwise withdrawn by the parent or legal guardian.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Image Consent Form

As part of Auburn Baptist Christian Academy's promotion of school activities or recognition of student achievement, staff members or the news media may photograph or video individual students or groups of students, while they are engaged in school activities not normally open to public. Your child's photographic image may thereafter appear in academy publications, newspapers or newscasts.

By signing below, I acknowledge that I have read this form and understand that my child's image may be used or seen on Auburn Baptist Christian Academy related materials, pictures or videos. I also understand that my child's image may also appear on publications outside of school but related/referring to Auburn Baptist Christian Academy and approved by the Academy.

Student's Name: _____

Parent / Guardian Printed Name: _____

Parent / Guardian Signature: _____

Date: _____

MODEL FORM

Religiously Exempt Child Day Center
Program Decision to Not Administer Prescription Medications

My program has made the following decision regarding the administration of medications to a child in my program: (Check one)

☒ I (or my staff) **WILL NOT** administer any medications – prescription or non-prescription medication (non-prescription medications include, but are not limited to, Tylenol, cough syrup, diaper ointment, sunscreen, and topical insect repellants).

☐ I (or my staff) will administer **ONLY** non-prescription medications (non-prescription medications include, but are not limited to, Tylenol, cough syrup, diaper ointment, sunscreen, and topical insect repellants).

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name (please print): Michael King	Facility Name: Auburn Baptist Christian Academy
Provider's Signature:	Date: 2-5-2020
Parent or Guardian Signature:	Date:

Confidentiality Statement

Information about any child in my program is confidential and will not be given to anyone except VDSS' designees or other persons authorized by law unless the child's parent or guardian gives written permission. Information about a child in my program will be given to the local department of social services if the child received a day care subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

Rehabilitation Act of 1973

I understand that if my program receives any federal funding (such as child care subsidy from a local department of social services), I am subject to Section 504 of the Rehabilitation Act of 1973 which is similar to the provisions of the Americans with Disabilities Act. If a child enrolled in my program now or in the future is identified as having a disability covered under the Rehabilitation Act, I will assess the ability of the program to meet the needs of the child. For further information on the Rehabilitation Act seek legal counsel and/or go to the following website: http://www.dol.gov/oasam/regs/statutes/sec504.htm

Provider Statement

I understand that it is my responsibility to follow my *Program's Decision Regarding Medication* plan and all health, infection control, and medication administration regulations applicable to my child day program. The Program Decision Regarding Medication plan will be made available to parents at enrollment, whenever changes are made, and upon request.