VIRGINIA DEPARTMENT OF EDUCATION
CHILD REGISTRATION MODEL FORM

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade or Class Level

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address /Email		Home Phone
Parent	Place Employed	Work Phone
Home Address /Email		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached 1.	Address 1.	Phone 1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or day care activities.

AGREEMENTS

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

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

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

SIGNATURES

_____ _____

Parent(s) or Guardian(s) ***Date***

_____ _____

Administrator of Center ***Date***

First Date of Attendance: _____ Last Date of Attendance: _____

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

OFFICE USE ONLY
IDENTITY VERIFICATION

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

Place of Birth	**Birth Date**	**Birth Certificate Number**	**Date Issued**
Other Form of Proof		**Date Documentation Viewed**	**Person Viewing Documentation**

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

_____

Date

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

Section § 22.1-289.049 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction, or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means..

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: ____/____/____

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: _____

RITA'S BRIGHT BEGINNING'S Photo

Permission

Child's name: _____

_____ I give permission for my child's picture to be posted on social media platforms (i.e. Facebook, Instagram, etc.).

_____ I give permission for my child's picture to be posted on the Brightwheel app.

_____ I give permission for my child's picture to be on display in the classroom.

_____ I **DO NOT** give permission for my child's picture to be used on social media platforms, the Brightwheel app or on display in my child's classroom.

Parent Signature: _____ Date: _____

Social Media Policy

Here at Rita's Bright Beginnings we understand that teachers, students, staff, and other school community members may use social networking/media (Twitter, Facebook, Instagram, blogs, etc.) as a way to connect with others, share educational resources, log travel experiences, and network within and outside of the SVCDC community. While social networking is fun and valuable, there are some risks we need to keep in mind when using these tools.

Social media refers to online tools and services that allow any Internet user to create and publish content. Many of these sites use personal profiles where users post information about themselves. Social media allows those with common interests to share content easily, expanding the reach of their ideas and work. Popular social media tools that SVCDC recognizes include Facebook, Twitter, LinkedIn, blogs, YouTube and Instagram.

Below are guidelines we expect our teachers, students and staff to follow while members of our RBB community. Whether you realize it or not, we are all representing our center on social media spaces, regardless of whether these are considered professional or personal spaces.

- **Use good judgment**
  Behave in a way that will make you and others proud and reflect well on RBB.
  Regardless of your privacy settings, assume that all of the information you have shared and will share in the future on social networks/online is public information.
- **Be respectful**
  Everyone teachers, staff , students, parents and families have the right to always be treated in a respectful, positive, and considerate manner.
- **Be responsible and ethical**
  Teachers should not interact with students on social media. We understand that our families may have relationships with staff outside of RBB but we expect all RBB community members (teachers, staff, students, parents, and families) to maintain professionalism online at all times.
- **Be a good listener**
- **Be accurate and appropriate**
- **Be confidential.**
  You may love posting pictures of your child at school, but other families may not be comfortable with their child's photo online.
  Do not publish, post, or release information that is considered confidential or private.
  Online "conversations" are never as private as you think they are.
  Use caution if asked to share your birth date, address, and cell phone number on any website.
- **Respect private and personal information**
  To ensure your safety, our staff's safety, and the safety of your children, be careful about the type and amount of personal information you provide.
  Never share or transmit personal information of students, parents, teachers, and staff without permission.
  Give proper credit to sources. In cases of doubt, privacy should be the default.

Generally do not use names of students. There may be special circumstances where a student is widely known for a particular achievement, in which case the use of the full name may be appropriate. If there is any doubt, use only first names or ask the Director or Owners of RBB for guidance.
Always respect the privacy of all of our SVCDC community members.

- **Own up to your mistakes and correct them immediately**
  Be sure to correct any mistake you make online immediately, apologize, and make it clear what you've done to fix the mistake.
  If it's a mistake that violates our policies regarding confidential information (e.g., exposing private information or reporting confidential information), please let the director and/or owners know immediately so the school can take the proper steps to help minimize the impact it may have.
  Staff members who do not report there mistake may be subject to discipline action, which may include suspension or termination of employment.
  Family members or parents who violate confidentiality of another student at SVCDC will need to meet with our Director and/or owners to determine what measures will be taken to ameliorate the situation.
- **Post images with care!**
  Respect brand, trademark, and copyright information. We may have students on a "Do Not Photograph" list. Take care that these children and students are not seen in ANY part of your photograph, even if they are turned away, not fully in the picture, blurry, or in the background.

In addition to these few points, we ask that you bring any questions or concerns with RBB to our Owners and Directors, directly. This will ensure that we get to the bottom of any problem that may arise!

Please do not post negative comments and concerns online. It reflects poorly not only on the center, but also on you as one of our community members.

I/we understand that RBB will take legal action against any and all posts and/or pictures shared to social media or online in general that violate the confidentiality of our staff, children, or center and/ or are slanderous in nature.

By signing this form, *you are agreeing to abide by this social media policy*. Any questions can be directed to our Program Director.

Signature_____ Date_____

Please circle as appropriate: STAFF PARENT

If parent, name of child_____

Rita's Bright Beginnings
"Imagination Starts Here"

Rita's Bright Beginnings
"Imagination Starts Here"

Parent Agreement for Admissions Child's Name_____

I have read all the information provided describing the program and am confident that RBB is able to adequately address my child's needs, based on my child's health, physical and emotional development. I have completed all forms and will provide RBB with any and all information requested. I agree to the program schedule and fees described below.

My child is enrolling: Full Time_____ Part Time_____

Days selected: Monday Tuesday Wednesday Thursday Friday

Applicable Fees: **$120 Registration Fee** AND **$120 SUPPLY FEE** due january and july.
$_____ Weekly tuition Fees

_____ **I/We understand and have read the parent handbook and agree to abide by all policies.**

_____ I/We understand that in the event I do remove my child from the program, I will give a 2-week notice IN WRITING or pay for that time

_____ I/We understand that if my account is not paid in full by Friday of the week care is being given that I will be asked to remove my child from the program and that I will be charged the 2 weeks notice fee as well as any late fees that may accrue.

_____ I/We agree to pick up my/our child by closing time (5:30pm) or be charged $15 for the first minute past closing, and $1 per minute after. (Note: Late fee may be waived by Director if a legitimate emergency exist, i.e. flat tire, 81. Working overtime does not constitute an emergency!) I understand that I must call at least 15 minutes before closing to notify staff that I will be late.

_____ I/We understand that if my/our child is left at the center 30 minutes after closing, and no one has called to notifyRBB that the child will be picked up late, that RBB policy is to notify Child Protective Services (CPS) that the child has not been picked up.

_____ I/We agree to call the center by 8:30 AM if my child will be coming in late or not at all. I understand that I must call by 8:30 AM to guarantee them a space for the day based on child-to teacher ratios.

_____ I/We understand that there are no tuition/fee deductions for absences (including illnesses, holidays, and school days or closed for ice or no power) I understand that the center may take up to 20 days per year for holidays, staff training, etc. and that these days have already been calculated into my yearly tuition.

_____ I/We understand that car seats may not be left at the center unless RBB has given prior permission to do so.

_____ I/We understand that RBB reserves the right to restrict the administration of medications. RBB will administer emergency medications only. I/We understand that if my/our child needs to receive emergency medications at the center, I/We will speak with the director, administrator, or owners and fill out all necessary forms required for my/our child to receive medications by MAT trained staff.

_____ I/We agree to abide by the social media policy. I/We understand that RBB will take legal action if I/we post or share any information and/or pictures that violate the confidentiality of our staff, students, or center; or are slanderous in nature. I/We will bring any concerns and questions about RBB policies and procedures to the director, administrator, or owners.

_____ I/We give permission for my child to be included in photographs and evaluations with the child's program.

_____ I/We understand that RBB withholds the right to terminate care and services provided by SVCDC if any of our center policies are not followed.

_____ I/We give permission for RBB and my/our child's school to share pertinent information with each other about my child.

I/We Agree to honor this contract.

Signature(s) of parent(s) or legal guardian(s):

_____ Date_____

Print: _____

_____ Date_____

Print: _____

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"Imagination Starts Here"