5000 Ridgedale Parkway
Richmond, VA 23234
Tel: (804) 275-5683; Fax: (804) 275-6429
www.thenobleacademy.com

IMPORTANT REMINDERS FOR THE 2022-2023 ENROLLMENT PERIOD:

Hours of Operation

- We are open Monday – Friday from 6:30 a.m. to 6:00 p.m.
- We are closed on the following holidays throughout the year: New Year's Day, Martin Luther King Jr. Day, President's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving, the Friday after Thanksgiving, Christmas Eve, and Christmas Day.

Late/Sick Child

- **ALL STUDENTS MUST BE AT OUR CENTER BY 10:00 A.M. WE CAN NOT ACCEPT CHILDREN AFTER THIS TIME UNLESS WE ARE AWARE OF YOUR SITUATION. (Please call by 9:30 a.m.)**
- **We are not allowed to keep sick children at our Center.**
    - If your child has a temperature of **99.6 (oral) or higher**; or under arm temperature (auxiliary) of 98.6 or higher, they are not allowed to attend. Child may return when they have been without fever (afebrile) for 24 hours.
    - Diarrhea – If your child experiences two or more loose stools in one hour, regardless of amount, they will need to be picked up by a parent or guardian. Child may return when diarrhea has ceased for 24 hours.

Medications

- We currently do not give medication at our Center. No medication is to be left in child's bag or belongings.

Outside Food/Food Allergies

- All food from your home must be labeled with your child's name and date. **We don't allow peanuts or peanut products at our facility.**
- If your child has a food allergy, you must fill out a form from the Center with their doctor's signature stating your child's allergic reaction and the protocol we must take in case of an allergic reaction. We will also need written permission from you to post your child's allergic reaction in our Center, so teachers will be aware when serving food.

Registration/Enrollment

- A Registration/Enrollment Fee of $100.00 (non-refundable) shall be paid at the time of initial application and at annual enrollment each August.
- The Academy reserves the right to deny, cancel, or suspend a child's enrollment at any time and at the sole discretion of the Center when it deems this action to be in the best interest of the child or the Center. In such an event, any unused Tuition will be refunded.

Discounts & Tuition (See Tuition Rates in Parent Handbook)

- 10% Sibling Discount (Discount applied to oldest Child's Tuition)
- 10% Teacher's Discount (Valid proof required)
- 10% Military Discount (Valid proof required)
- 15% Combination Discount – Teacher/Military/Sibling (Discount applied to oldest Child's Tuition)
- Tuition is due on Mondays and will be considered late if paid after Wednesday of each week.
- Tuition is not prorated and is owed and due in full on a weekly basis.
- Tuition is not refunded for Vacations, Unused Days, Holidays, Inclement Weather Closings, and/or an "Act of God" that results in a change in hours of operation.
- Payment Methods Accepted:
    - Pay by Pro-Care's "**Tuition Express**" (*Preferred method)*
    - Pay by Check
    - Pay by Money Order
    - Cash Accepted *(Exact Amount Only)*

Fees

- Payments are processed **automatically** through "**Tuition Express**" through your checking or credit card account.
- $25 – Late Payment Fee is assessed to all payments received after Wednesday. (*All late payment fees must be paid prior to or up to submitting future Tuition Payment*.)
- $35 – Returned Check Fee - Payable at time of restitution *(After 1st occurrence, checks can no longer be used. You may pay via Tuition Express, cash, or Money Order.)*
- Late Pick-up Fee-$5.00 for every five (5) minutes beginning at 6:05 p.m. and after 6:15 p.m., $2 *per minute* until picked up.
- $8.00 After 1st warning: if we do not get a phone call that your child does not need to be picked up from school. (School Age Children)

Student Withdrawal

- When withdrawing your child, you must give us a written two-week notice. If a two-week notice is not given you will be liable for the next week's tuition.

SIGNATURE

By signing this form, I __________________________ (Parent Name) agree to abide by the policies of The Noble Academy, Inc. and agree to pay any applicable fees as stated herein.

____________________________	________________________	__________________
Signature of the Parent or Guardian	Name (Printed)	Date

A copy of the Parent Handbook can be found on our website www.thenobleacademy.com .

THIS REGISTRATION PACKET MUST BE COMPLETELY FILLED OUT IN ORDER FOR YOU CHILD TO BE REGISTERED WE WILL NEED BIRTH CERTIFICATE, S.S CARD (VIEW), $100 ANNUAL REGISTRATION FEE, AND IMMUNIZATION AND PHYSICAL RECODS (Pt. 1-3)

REGISTRATION for Enrollment

Name of the child			Nickname	Sex	Date of Birth
Last	Middle	First			
Full Address:					Telephone #:
Chronic Physical Problems/Pertinent Developmental Information/ Special Accommodations Needed:					
If Child Attends This Center and Another School/ Program, Give Name of School/Program:					Grade
Previous Child Day Care Programs and Schools Attended:					

PARENT(S)/GUARDIAN(S)

Father:	Place Employed and Address:	Business Phone:	
Home Address:	E-Mail Address:	Home Phone:	Cell Phone:
Mother:	Place Employed and Address:	Business Phone:	
Home Address:	E-Mail Address:	Home Phone:	Cell Phone:

Person(s) or Agency Having Legal Custody of Child: Parents.	
Home Address:	Home Phone:
Business Address:	Business Phone:

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency:	
Child's Physician:	Address/Telephone #:

TWO EMERGENCY CONTACTS IF PARENT(S) CAN NOT BE REACHED

1. Name:	2. Name:
Address:	Address:
Telephone #:	Telephone #:

PERSON(S) AUTHORIZED TO PICK UP CHILD

Name:	Relationship to child:	Name:	Relationship to child:
Name:	Relationship to child:	Name:	Relationship to 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 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 must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day care activities.

WE MUST HAVE COMPLETE ADDRESS ALONG WITH PHONE NUMBER FOR YOUR 2 EMERGENCY CONTACTS.

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Enrollment Agreement/Contract

This Enrollment Agreement, effective the ______ day of ____________________ 20_____ is between The Noble Academy, Inc. ("School") a privately-owned child care Center, located at 5000 Ridgedale Parkway and____ (Parent)

1. The Noble Academy, Inc.'s non-refundable registration fee of $100 shall be paid annually in August or at the time of initial application.
2. Weekly tuition, per our current fees schedule, is due on or before the 1st work day of each week. A **$25.00** late fee shall be charged for any weekly tuition payments received after the third day of each week. If weekly tuition fees (including any applicable late fees) are not received at the Center five work days after the due date, the child will not be readmitted to the program. If payment is not made when due, interest shall accrue at **1.5%** per month (**18% per year**) and the parent is responsible for all costs and fees associated with the collection process including but not limited to billing costs, collection costs, attorney's fees, which are deemed reasonable as **33 1/3%** of the amount owed, and court costs as may be required to collect the amount owed.
3. A second child in the same family shall receive a **10% discount** on the lower of the two tuitions.
4. Weekly tuition fees are non-refundable regardless of holidays, illness, vacation, inclement weather days or "Acts of God". The Academy will make reasonable efforts to in inclement weather; however, the Academy may choose to close at the School's discretion. Parents should call the school voice mail regarding closings or watch WRIC Channel 8.
5. This Academy is closed on the following days:
   - Labor Day
   - Thanksgiving Day
   - Christmas Eve
   - Christmas Day
   - New Year's Day
   - Martin Luther King, Jr. Day (observed)
   - Memorial Day
   - Independence Day
   - President's Day
   - Veteran's Day
   - Good Friday
   - Juneteenth

6. The Noble Academy will open at **6:30 a.m.** and close **6:00 p.m**. A late pick-up fee of **$5.00** for every five (5) minutes beginning at **6:05 p.m.** and after **6:15 p.m.**, and an additional **$2 <u>per minute</u>** until picked up. Fees for late pick-up are payable immediately: unless there had been an agreement between the Executive Director and the parent. Otherwise, if the fee is not paid for late pick up the child will not be re-admitted into the program. Consistent lateness will be cause for the child's dismissal from the Academy. A fee of **$30.00** will be charged for checks returned by the Academy's bank.

7. At the time of enrollment, the child shall be scheduled for specific days and times. Additional days may be added for an additional fee; however, the Academy's executive director must be contacted at least 2 hours in advance of any added day. Additional days are offered based on enrollment and may not always be available. The director must approve any other schedule changes in advance.

8. A non-refundable deposit of one week's tuition is required for applications received 30 to 60 days prior to the child's enrollment. If deposits are not paid, a place for the child cannot be guaranteed. Deposits are applied to weekly tuition fees. **The Center requires a two-week written notice of withdrawal. If two weeks' notice of withdrawal is not provided, the standard tuition fee shall be charged for that period.**

9. The Academy reserves the right to deny, cancel or suspend a child's enrollment at any time the Center, in its sole discretion, deems such action to be in the best interest of the child or the Center. In such event, any unused tuition will be refunded.

10. Children may not attend the Center while ill, children who become ill at the Academy must be picked up immediately (refer to health policy guidelines). If the child will be absent, the absence should be reported to the Academy by 9:30 a.m.

11. If Parents engage employees of the Academy from time to time for outside child care services, (Outside Engagements), Parents agree that Outside Engagements are not related to The Noble Academy, Inc. or its owners. With respect to Outside Engagements, Parents release and discharge the Academy, its owners, their present or former officers, employees, shareholders, affiliates, heirs, successors and signs, in their individual or corporate capacities (the "Owners' Release"), from all claims, demands, liabilities, actions or cause of action whatsoever, whether known or unknown, which parents have, may have, or claim to have, at any time in the future against the Owners' Release based in whole or in part on, or arising out of, or related to, any Outside Engagements.

I understand the terms of this agreement and agree to be bound by them. I have received and executed copy of this agreement and a copy of the parents' handbook, which includes the health policy referenced in paragraph 10.

SIGNATURES

Signature of the Parent or Guardian	Name (Printed)	Date
Signature of Executive Director	Name (Printed)	Date

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AGREEMENTS

The Noble Academy, Inc. agrees to notify the parent(s)/guardian(s) whenever their 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.

The parent(s)/guardian(s) authorize The Noble Academy, Inc. to obtain immediate medical care if any emergency occurs when parent(s)/guardian(s) cannot be located immediately. **

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

SIGNATURES

______________________	______________________	__________
Signature of the Parent or Guardian	Name (Printed)	Date
______________________	______________________	__________
Signature of the Executive Director	Name (Printed)	Date

OFFICIAL USE ONLY
IDENTIFY VERIFICATION

Attached

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

____
Date

63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program shall be destroyed upon conclusion of requisite period of retention. The procedures for the disposal, physical on or other disposition of proof of identity containing social security numbers shall include all reasonable steps such documents by (i) shredding, (ii) erasing, (iii) otherwise modifying the social security numbers in those records them unreadable or indecipherable by any means. 252/11(06/05)

**If the parent(s)/guardian(s) do not answer on the first call attempt, the Noble Academy reserves the right to call 911, depending on the severity of the situation.
***Definition - Communicable Disease: An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means.

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The Virginia Department of Social Services requires that childcare centers document any schools or childcare centers previously or currently attended.

Date: ________________________

Child's Name: ______________________________________

Previous Childcare Centers or Preschools attended:

1. ____
2. ____
3. ____

Current Elementary School attending (if applicable):

School: ____ Grade: _____

Office Use Only
Identity Verification

Place of Birth: ____________________________ Birth Date: ______________________________

Birth Certificate Number: ___________________ Date Issued: _____________________________

Other Form of Proof: _______________________

Proof of child's identity may include a certified copy of the child's birth certificate, birth registration card, notification of birth passport, etc. Viewing a child's proof of identity is not necessary when the child attends a public school in Virginia and the Center assumes direct responsibility for the child directly from the school. While programs are not required to keep proof of the child's identity, documentation of viewing this information must be maintained for each child.

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Password Form

It is part of our security policy to have a password that is given to anyone whom you designate as an authorized pick-up for your child. Your child will be released to this authorized person only if the following conditions have been met:

1. The Director must be notified in writing, either at the time of enrollment, or in advance of the pick-up, that you are authorizing someone other than yourself to pick-up your child. If you telephone the day care to authorize a pick-up, be prepared to receive a return phone call to verify the information.

2. At the time of notification, you will need to give us the authorized individual's full name and his/her approximate time of arrival, so we can then notify staff.

3. The authorized individual must show two forms of identification (preferably one photo ID) and tell the supervising teacher the password you have designated below.

4. The authorized individual will be responsible for signing your child out of the building.

The password is an added measure of security for your family and will be kept with your child's emergency information.

Child's Name:
____

Password: ____

Teacher: ____

Parent's Signature: ____

Date: ____

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Policy and Photo Release

My signature below grants The Noble Academy the right to film, photograph, record, tape, reproduce and distribute my child's image, voice, etc. and use such for the purposes of publicity, advertising promotions, or for any other reasonable purpose in relation to The Noble Academy.

My signature below also confirms my understanding of the agreement, school policies, my tuition obligation, my responsibility for the payment of fees, and confirms that I have received and read a copy of the parent handbook.

SIGNATURE

______________________________	______________________________	______________________________
Signature of the Parent or Guardian	Name (Printed)	Date

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Medical and Transportation Waiver

The undersigned authorize The Noble Academy, Inc. and consent to any emergency diagnostic procedure or medical care for my child, Child's name ___________________________________ which is rendered under supervision of licensed physician on staff of _______________________ Hospital. Regardless of where the care is provided, the undersigned also authorize representatives of The Noble Academy, Inc., to transport my child to receive care. This authorization is given in advance of any specific need for treatment to provide authority to The Noble Academy, Inc., to consent to any emergency care recommended by the physician.

The undersigned irrevocably release any claims, demands, actions or cause of action against The Noble Academy, Inc., respective representatives, and employees, which arise from or relate to the transportation of my child and any medical care provided.

This authorization and waiver shall remain effective until I request changes in writing or withdraw my child from The Noble Academy, Inc.

SIGNATURE

_______________________	_______________________	___________
Signature of the Parent or Guardian	Name (Printed)	Date

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Allergic Food Reaction

If your child has an allergic reaction to a certain food, you must fill out an “Action Plan for Allergic Reactions” form with us. This form must be filled out by your child’s physician. Children who require an Epinephrine parent’s must fill out a “Food Allergy & Anaphylaxis Care Plan” form. This form must be filled out by your child’s physician. Your signature below gives us permission to post in our classroom that your child has an allergic reaction to a certain food. By posting in our classroom, it alerts our teachers that your child cannot consume certain foods due to an allergy.

SIGNATURE

______________________________	____________________________________	______________
Signature of the Parent or Guardian	Name (Printed)	Date

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DSS Contract

(ONLY TO BE SIGNED BY DSS CLIENTS)

We are happy to collaborate with Department of Social Services (DSS) to provide your child(ren) with exceptional child care services. It is imperative that we all work as a team and maintain open lines of communication.

If you have problems with your card or lose your card, please let us know and call the Parent Help Line at 877-918-2322. Keep a copy of your card number in a secure location as you will need it to receive assistance from the Help Line. Take a picture of your card with your phone.

If you have a **co-payment**, you must make these payments each **month no later than the fifteenth of the month**. Afterwards, a late fee will be added to the following week's fees. Failure to pay the amount due or to make the appropriate arrangement for payment, will result in the Center contacting DSS and they will close your case.

It is **VERY IMPORTANT** to Swipe your card daily. Remember, your swiping is the only means for The Noble Academy, Inc. to get paid for the services rendered to you and your children. If you receive **DENIED** when you swipe, please **STOP,** and get help from the office personnel. If you run out of absences, you are responsible for paying for the days not put into the system. If we must perform a manual billing for your child(ren) you will be charged **$10.00** for each billing.

It is **YOUR** responsibility to **KEEP CONTROL OF YOUR CARD ALWAYS – DON'T LOSE IT**.

SIGNATURE

____________________________	________________________________	____________
Signature of the Parent or Guardian	Name (Printed)	Date

DON'T SIGN THIS IF YOU DO NOT HAVE A CONTRACT WITH DSS

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Child and Adult Care Food Program

Instructions

All Centers participating in the Child and Adult Care Food Program (CACFP) must annually provide the information media serving the area with a public release. Centers are not required to pay for its publication, but they are required to make the public release available to the public information media. Do not send your public release to the public information media until after receiving notification approval from the office.

****

CACFP Non-pricing Child and Adult Day Care Centers

The Noble Academy, Inc. announces the sponsorship of the **Child and Adult Care Food Program (CACFP).** The same meals will be available at no separate charge to all participants at each CACFP facility without regard to race, color, sex, national origin, age, disability, or sexual orientation. To file a complaint, complete the USDA Program Discrimination Complaint Form, AD-3027 found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office or write a letter addresses to USDA and provide in the letter all the information requested in the form.

To request a copy of the compliant form, call (866) 632-9992. Submit you completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington D.C. 20250-9410
Fax: (202) 690-7442
Email: **program.intake@usda.gov.**

THE CACFP FORMS ARE TO BE COMPLETELY FILLED OUT BY ALL FAMILIES ENROLLED IN THE NOBLE ACADEMY, INC.

Meals will be provided at, The noble Academy Inc.
For further information, please contact: William D. Noble Jr / (804) 275-5683
You may also contact the VA. CACFP at VDH Division of Nutrition for more information by calling 1-877-618-7282 or emailing CACFP@vdh.virginia.gov

CHILD LETTER TO HOUSEHOLD (PARENTS/GUARDIANS)
MEAL BENEFIT INCOME ELIGIBILITY FORM

Dear Parent or Guardian:

This center/home participates in the United States Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Please return the completed IEF back to the center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of the Virginia Department of Social Services or the court, children are categorically eligible for meal benefits regardless of household income.

If the household income is over the income guidelines listed below, the family is not required to complete this application. Instead, please write the child's name on the IEF and return it to the center. Please notify the center staff if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

Family Access to Medical Insurance Security Plan (FAMIS)

FAMIS is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. ***FAMIS Plus*** is Virginia's name for children's Medicaid. ***FAMIS Plus*** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section on the application for *FAMIS* or *FAMIS Plus*, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on *FAMIS* is available at 1-866-873-2647 – Interpreters are available. Log onto www.famis.org to apply online.

A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-price meals:

Household Size	Yearly
1	$23,107
2	$31,284
3	$39,461
4	$47,638
5	$55,815
6	$63,992
7	$72,169
8	$80,346
Each additional person:	$8,177

Please feel free to contact the center at (______)________-__________ with questions or concerns.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found on-line at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

Virginia Child and Adult Care Food Program (CACFP)
(Child) Annual Enrollment Form (AEF)

CENTER/PROVIDER COMPLETE THIS SECTION

Center/Provider Name			
		VA	
Street Address	City	State	Zip Code

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 6 below**.

This form is required for:	This form is NOT required for:
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK			4 MEALS RECEIVED
	☐ Monday	TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	☐ Breakfast
Child's First Name	☐ Tuesday				☐ AM Snack
Child's Last Name	☐ Wednesday				☐ Lunch
Date of Birth (mm/dd/yyyy)	☐ Thursday	NOTES:			☐ PM Snack
Age	☐ Friday				☐Supper
	☐Saturday				☐ EV Snack
	☐ Sunday				

5 Parent/Guardian Signature and Date: ***By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.***

Printed Name:	***Signature:***
Street Address:	***City, State, Zip Code:***
Phone Number HOME / WORK / CELL (circle one):	***Date:***

Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color , national origin , sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877- 8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632- 9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

6 Ethnic and Racial Identification: ***Parent/Guardian to complete. Please select <u>ONE</u> Ethnicity; Please select <u>ONE OR MORE</u> Races***

ETHNIC IDENTIFICATION

O **Hispanic , Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

O **Not Hispanic, Latino or Spanish origin**

O **I decline to answer.**

RACIAL IDENTIFICATION

O **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos).	O **Black, African American, or Haitian:** A person having origins in any of the black racial groups of Africa.
O **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	O **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
O **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	O **I decline to answer.**

NOTES:

Information on this form must be kept confidential.

Child Care Representative Use Only

Effective Date of This Enrollment Form:	*The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.*
(mm/dd/yyyy)	
Effective Withdrawal Date of This Enrollment Form:	
(mm/dd/yyyy)	
Printed Name of Center Representative	*This form is effective for 12 months from the date of parent signature.*
Signature of Center Representative	

CONFIDENTIAL

This institution is an equal opportunity provider.

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF)FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

1 All Household Members				2	3
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]				FOSTER CHILD	SNAP, TANF or FDPIR CASE #
	First, Middle Initial, Last	Check if **NO** income	Ages of children in care	Skip to Part 6 if all are foster children.	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. **SNAP AND TANF MUST BE NINE (9) DIGITS**
1		☐		☐	
2		☐		☐	
3		☐		☐	
4		☐		☐	
5		☐		☐	
6		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	**GROSS INCOME AND HOW OFTEN IT IS RECEIVED** (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often	Amount	How often	Amount	How often	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X – X X – ____________
Social Security Number

☐ **I do not have a social security number.**

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) ( ) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS* , the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: ________________ Sign here: ________________________________

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12** Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $_______________ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** __________

☐ **FREE** based on:			☐ **REDUCED** based on:	☐ **DENIED** reason:	
☐ foster child	☐ migrant	☐ SNAP, TANF, FDPIR	☐ household income	☐ income too high	☐ incomplete application
☐ homeless	☐ runaway	☐ household income		☐ non-qualifying SNAP/TANF	

SECTION B **Signature of Determining Official:** ________________________________ **Date:** ________________________

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400
Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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SAMPLE

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.)

Certification of Immunization 03/2014

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:** ____

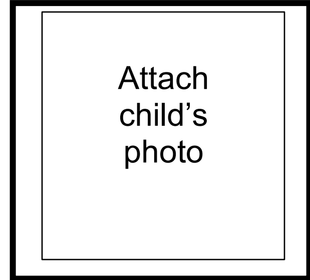
Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: ________________________________ **Date of plan:** ______________

Date of birth: ____/____/______ **Age** ______ **Weight:** _________kg

Child has allergy to ____



Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): ____________________. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): ________________________________ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): ______________________________ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): ____

______________________________ ______________ ______________________________ ______________
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
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Child's name: ________________________ **Date of plan:** ________________________

Additional Instructions:

Contacts

Call 911 / Rescue squad: ________________________

Doctor: ________________________ Phone: ________________

Parent/Guardian: ________________________ Phone: ________________

Parent/Guardian: ________________________ Phone: ________________

Other Emergency Contacts

Name/Relationship: ________________________ Phone: ________________

Name/Relationship: ________________________ Phone: ________________

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This information should not take the place of talking with your child's doctor.

Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: ____
(Child's name)

____has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: ____

Dosage and times to be administered: ____

Special instructions (if any): ____

____

This authorization is effective from: ____________________________until: ________________________
(Start date) **(End date)**

Parent's or Guardian's Signature: ____ **Date**: ______________

Section B: to be completed by child's physician

I, ____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to:____________________________________ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): ____

Dosage and Times to be administered: ____

Special instructions (if any): ____

____

This authorization is effective from: ____________________________until: _________________________
(Start date) **(End date)**

Physician's Signature: ____ **Date**: ____________________

032-05-0570-05-eng (06/12) Physicians Phone: _________________________________