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

The Noble Academy Policies and Procedures

Parent Awareness and Consent Document

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, Presidents' Day, Good Friday, Memorial Day, Juneteenth, Independence Day, Labor Day, Veteran's Day, Thanksgiving, the Friday after Thanksgiving, Christmas Eve, and Christmas Day.

Tuition and Fee Policies

- Tuition and After Market rates are due every Monday and will be considered late after Wednesday.
- DSS co-payments are due on the 1st of each month.
- All tuition and after-market rates are based on the space your child is using at The Noble Academy, not on attendance. This means that payment is required regardless of whether your child is present or absent during the week.
- Payments are processed through Brightwheel using your checking or credit card account.

Please be aware that all DSS parents are also required to pay a $25.00 weekly per child After Market rate. A $25 late payment fee will be assessed for all payments received after Wednesday and must be paid prior to submitting future tuition payments. Returned checks incur a $35 fee, and after the first occurrence, checks can no longer be used; payment

must be made via cash or Money Order. Late pick-up fees are $5 for every 5 minutes beginning at 6:05 p.m., and after 6:15 p.m., $2 per minute until picked up. An $8.00 fee will be charged after the first warning if we do not receive a phone call regarding your child's pick-up needs (School Age Children).

Registration/Enrollment

- A Registration/Enrollment Fee of $100.00 per child (non-refundable) must be paid at the time of initial application.
- The Academy reserves the right to deny, cancel, or suspend a child's enrollment at any time at the sole discretion of the Center when deemed in the best interest of the child or center. Any unused tuition will be refunded in such cases.

Discounts

- 10% Sibling discount (applied to oldest child's tuition)
- 10% Teacher's discount (valid proof required)
- 10% Military discount (valid proof required)
- 15% Combination discount for Teacher or Military and Sibling (applied to oldest child's tuition)

Student Ratio Policy and Classroom Closures

The Noble Academy follows strict student-to-teacher ratio guidelines as mandated for childcare centers to ensure safety, quality, and appropriate supervision of all children. We strive to maintain these ratios at all times; however, there may be instances when classrooms must be closed due to insufficient staffing. In such cases, our team will do our very best to notify parents ahead of time if a classroom closure is necessary. We appreciate you're understanding and cooperation as we prioritize the well-being and safety of all children in our care.

Late/Sick Child Policy

- All students must be at our center by 10:00 a.m. We cannot 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°F (oral) or higher; or underarm (axillary) temperature of 98.6°F or higher, they must stay home. Children may return when they have been fever-free (afebrile) for 24 hours.
- Diarrhea: Two or more loose stools in one hour, regardless of amount. Child may return when diarrhea has ceased for 24 hours.

Medications

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

Outside Food and Food Allergies

- All food from home must be labeled with your child's name and date.
- We do not allow peanuts or peanut products at our facility.
- If your child has a food allergy, you must complete our form with a doctor's signature stating your child's allergic reaction and protocol. Written permission is also required to post your child's allergy information for staff awareness when serving food.

Student Withdrawal

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

Important Parent Consent

By signing this document, you acknowledge and consent to all policies, procedures, and guidelines stated herein for The Noble Academy. You understand that tuition and after-market rates are based on the space your child is using and not on attendance, and agree to abide by all payment schedules, student ratio policies, and classroom closure procedures. Your cooperation helps us maintain a safe, nurturing, and effective learning environment for all children.

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 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 YOUR CHILD TO BE REGISTERED. WE WILL NEED BIRTH CERTIFICATE, S.S. CARD(VIEW), $100 ANNUAL REGISTRATION FEE, AND IMMUNIZATION AND PHYSICAL RECORDS (PART 1-4)

REGISTRATION for Enrollment
(Subsidy Inspection Requirements for Child Day Centers 22VAC40-665-520)

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

WE MUST HAVE COMPLETE ADDRESSSES 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 childcare 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 workday 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 by 5 workdays 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 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:

   - New Years' Day
   - Presidents' Day
   - Martin Luther King, Jr. Day
   - Good Friday
   - Memorial Day
   - Thanksgiving
   - The day after Thanksgiving
   - Christmas Eve
   - Christmas
   - Juneteenth
   - Independence Day
   - Labor Day
   - Veteran's Day

6. The academy will open at **6:30 a.m.** and close at **6:00 p.m**. A **fee of $5.00** will be charged for any child for the first **15 minutes** and an additional **$5.00 per child per 5 minutes** period thereafter. Fees for late pick-up are payable immediately: unless there has 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 caused by 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 an 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 is absent, the absence should be reported to the academy by 9 a.m.

11. If parents engage employees of the academy from time to time for outside childcare 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 know 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.

Non-Discrimination Policy

Consistent with the truth that God's grace and His love through Jesus Christ extend without partiality to all mankind, The Noble Academy, Inc admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate based on race, color, national and ethnic origin in administration of educational policies, admissions policies, and other school-administered programs. The Noble Academy, Inc., does not teach any doctrine or is affiliated with any church or religious organization.

.

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

_____ _____

Signature of the Parent or Guardian Date

_____ _____

Signature of the Executive Director Date

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AGREEMENTS

The Noble Academy, Inc 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.

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

_____ _____

Parent(s) or Guardian(s) Date

_____ _____

Administrator of Center 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)

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

My signature below 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 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 withdraw my child from The Noble Academy, Inc.

Parent/Guardian Signature: _____

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 parents 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 can't consume certain foods due to allergic reactions.

Parent/Guardian Signature: _____

Name (Printed): _____

Date: _____

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DSS Contract

(ONLY TO BE SIGNED BY DSS CLIENTS)

We are happy to collaborate with the Department of Social Services (DSS) to provide your child(ren) with exceptional childcare 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 will result in the center contacting DSS and they will close your case. In addition, All **DSS parents** are also required to pay a **$25.00** weekly per child After Market rate.

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**.

_____ _____

Parent/Guardian Name Signature

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

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
		TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	
Child's First Name	☐ Monday				☐ Breakfast
	☐ Tuesday				☐ AM Snack
Child's Last Name	☐ Wednesday				☐ Lunch
	☐ Thursday				☐ PM Snack
Date of Birth (mm/dd/yyyy)	☐ Friday	NOTES:			☐ Supper
	☐ Saturday				☐ EV Snack
Age	☐ 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 ONE Ethnicity; Please select ONE OR MORE 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: *(mm/dd/yyyy)*	***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.***
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	

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

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]			2	3
	First, Middle Initial, Last	Check if NO income / Ages of children in care	FOSTER CHILD Skip to Part 6 if all are foster children.	SNAP, TANF or FDPIR CASE # 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, 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.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339..

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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.

VIRGINIA CACFP
Child and Adult Care Food Program

Fill this form out only if you are enrolling an Infant child

PARENT/GUARDIAN CHOICE FORM (INFANT)

NAME OF INFANT:	_____ (First Name, Middle Initial, Last Name)	DATE OF BIRTH:	_____ (mm/dd/yyyy)

This center/provider participates in the Child and Adult Care Food Program (CACFP) and receives Federal USDA funding for serving nutritious meals to infants and children. Participation in the CACFP requires caregivers to follow specific meal patterns according to age group classifications detailed in forms *CACFP-009 Child Meal Pattern* and *CACFP-010 Infant Meal Pattern*.

(Center/Provider)_____ agrees to feed your infant breast milk provided by parent/guardian. The center/provider will provide iron-fortified infant formula. The formula provided is_____.

Federal regulations require centers/providers participating in the CACFP to offer iron-fortified formula to infants who are in care during meal service times. Parents/guardians may decline the center/provider offered formula and supply the infant's formula, provide expressed breastmilk, or breastfeed on site.

PLEASE INDICATE PREFERENCES (Choose all options that apply by initialing and dating in the appropriate spaces.)	BIRTH – 5 MONTHS	6 MONTHS – 11 MONTHS
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED FORMULA	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE FORMULA	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____
OPTION 3: PARENT/GUARDIAN WILL PROVIDE EXPRESSED BREASTMILK	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____
OPTION 4: BREASTFEEDING WILL OCCUR ON SITE	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____

BREASTFEEDING FRIENDLY CENTERS/PROVIDERS ARE ENCOURAGED!

Many centers and providers now have designated space onsite for breastfeeding.
Ask your center representative or day care home provider for details!

Federal regulations also require centers providers participating in the CACFP to provide iron-fortified infant cereal and other foods when the child is developmentally ready.

PLEASE INDICATE PREFERENCES	BIRTH – 5 MONTHS	6 MONTHS – 11 MONTHS
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED CEREAL AND OTHER FOODS BASED ON THE CACFP MEAL PATTERN	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____
OPTION 2: PARENT GUARDIAN WILL PROVIDE CEREAL AND SOLID FOODS WHEN THE TIME IS APPROPRIATE	INITIALS:_____ DATE:_____	INITIALS:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

1. THIS FORM MUST BE KEPT **CURRENT, ACCURATE AND ON FILE** FOR EACH INFANT ENROLLED IN CHILD CARE UNTIL THE INFANT REACHES 1 YEAR OF AGE OR IS NO LONGER ON BREASTMILK OR INFANT FORMULA.
2. BREASTMILK IS AN ACCEPTABLE MILK SUBSTITUTE FOR CHILDREN OF ANY AGE WITHIN THE CONTEXT OF THE CACFP.
3. AS SITUATIONS CHANGE, SUCH AS A MEDICAL AUTHORITY CHANGING AN INFANT'S FORMULA, A NEW FORM MUST BE COMPLETED.
4. IF THE PARENT/GUARDIAN DECLINES THE FORMULA AND THE CENTER/PROVIDER PROVIDES AT LEAST ONE **REQUIRED** MEAL AND/OR SNACK COMPONENT, THE MEAL OR SNACK MAY BE CLAIMED FOR REIMBURSEMENT.
5. IF THE PARENT/GUARDIAN DECLINES INFANT MEALS/SNACKS, THEY MAY NOT BE CLAIMED FOR REIMBURSEMENT.

Parent must fill out Part I of this doc, and sign.

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

Part I – HEALTH INFORMATION FORM

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

Name of School: _____

Student's Name: _____ Current Grade: _____
Last First Middle

Student's Date of Birth ___/___/___ Sex _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City _____ State _____ Zip Code _____

Name of Parent or Legal Guardian 1: _____ Phone ___-___-___ Work or Cell: ___-___-___

Name of Parent or Legal Guardian 2: _____ Phone ___-___-___ Work or Cell: ___-___-___

Emergency Contact: _____ Phone ___-___-___ Work or Cell: ___-___-___

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions

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

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

Box 2. Medications

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

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

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

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

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

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

Signature of Parent or Legal Guardian _____ Date: ___/___/___

Signature of Interpreter: _____ Date ___/___/___

COMMONWEALTH OF VIRGINIA

SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

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

Section I

See Section II for conditional enrollment and exemptions.

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

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

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

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

Certification of Immunization

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ___/___/___

Weight: _____ lbs Height: _____ ft _____ in

Body Mass Index (BMI): _____ BP _____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

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

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

Tuberculosis Screening

Check the box that applies:

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

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

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

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

Blood Lead: _____ Hct/Hgb _____

Developmental Screen

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

Hearing Screen

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

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously Identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

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

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

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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

Summary of Findings (check one):

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

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

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

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

_____ **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:** _____

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

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

Section II
Conditional Enrollment and Exemptions

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

Student's Name: _____ Date of Birth: |____|____|____|

Parent or Legal Guardian Name: _____

Parent or Legal Guardian Name: _____

Phone Number: _____

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

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[____]; RV:[____]; Measles :[____]; Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

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

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

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

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

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

Section III Requirements

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

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

(Requirements are subject to change.)