Word Performance Child Development Center and Academy

17902 S. Main St., Dumfries, VA 22026 Phone: 571-931-6380 E-mail wordperformance@yahoo.com

2018-2019 Enrollment Form

STUDENT INFORMATION:

Child's Name_____Age_____Nickname_____
Address_____Phone:_____
Male □ Female □ Date of Birth_____SSN_____
Attends Public School: Yes □ No □ Name of School _____

PARENT/GUARDIAN INFORMATION:

Full Name_____Relationship_____
Address_____
Home Phone_____Cell Phone_____
Work Phone_____E-mail _____
SSN_____Drivers Licence # and State_____
Employer_____
Employer Address_____

PARENT/GUARDIAN INFORMATION:

Full Name_____Relationship_____
Address_____
Home Phone_____Cell Phone_____
Work Phone_____E-mail _____
SSN_____Drivers Licence # and State_____
Employer_____
Employer Address_____

MEDICAL INFORMATION:

Doctor_____Hospital Preference_____
Address_____Telephone_____
Dentist_____
Address_____Telephone_____
Allergies (Please discuss with administration)_____
_____

Has your child had or now have any of the following:
□ Measles □ Mumps □ Chicken Pox □ Whooping Cough □ Premature Birth □ Colic
□ Seizures □ Birth Injury □ Head Injury □ Heart Problems □ Hives □ Lung Problems
Is your child currently on any medication or breathing treatments? _____ If yes please list_____
_____

Is there any special information we need to know to care for your child? _____
_____

Alternate Contacts/ Authorized to pick up (List at least two):
Name _____Telephone #_____Relationship_____
Name _____Telephone #_____Relationship_____
Name _____Telephone #_____Relationship_____

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2018-2019 Enrollment Form Continued

AGREEMENTS:

The center agrees to inform the PARENT(S)/GUARDIAN(S) whenever your child becomes ill. Also, the PARENT(S)/GUARDIAN(S) AUTHORIZES THE CENTER TO OBTAIN IMMIDIATE MEDICAL CARE IF AN EMERGENCY OCCURES AND THE PARENT(S)/ GUARDIAN(S) CAN NOT BE LOCATED IMMEDIATELY. THE CENTER HAS THE PARENT(S)/GUARDIAN(S) PERMISSION TO CALL THE CHILD'S FAMILY PHYSICIAN IN AN EMERGENCY WHEN THE PARENT(S)/GUARDIAN(S) CAN NOT BE CONTACTED. WHEN THE PARENT(S)/GUARDIAN(S) OR THE CHILD'S PHYSICAN CANNOT BE CONTACTED THE CENTER HAS PERMISSION TO CALL 911 FOR MEDICAL ASSISTANCE AT THE PARENT(S)/GUARDIAN(S) EXPENCE.

Signature of Parent/Guardian_____Date_____

FINANCIAL STATEMENTS OF UNDERSTANDING:

1. I agree to pay each week that my child is registered. **Tuition is paid weekly in advance.** Weekly payments are due on Monday of each week. **A late payment fee of $10.00** will be assessed if payment is not received by close of business on Tuesday. Each day after that a $5.00 fee will be added to your account until the account is paid in full.
2. I understand that services will be terminated if my account becomes **one week** in arrears. If services are terminated, I understand I must pay a re-registration fee to re-enroll my child back into the center.
3. I understand that if my account becomes one week past due I am required to pay whatever fees are incurred by the center while trying to recoup my unpaid balance.
4. I understand that **no fees will be refunded.** I understand that I am required to **give TWO WEEKS** written notice prior to withdrawal of my child. **I understand that without this notice, I am liable to pay two weeks tuition.**
5. I agree to pay the late pick-up fee of **$1.00 per minute** per family, after (6:35pm for the CDC and those paying for before and after care) (3:30 for academy students not paying for before and after care) whenever my child(ren) is/are cared for after their designated time. I agree to pay this fee at the time my child(ren) is/are picked up.
6. I agree to pay the book and supply fee (if applicable) upon my child(ren)'s registration.
7. **I UNDERSTAND THAT I AM ALLOWED 2 VACATION WEEKS DURING A SINGLE CALANDER YEAR, DURING WHICH TIME MY CHILD(REN)'S REGISTRATION WILL BE MAINTAINED. ONE HALF OF THE WEEKLY TUITION IS CHARGED FOR THESE WEEKS. IT MUST BE PAID IN ADVANCE OF THE VACATION, TO AVOID A LATE FEE. IF NOT PAID IN ADVANCE THE LATE PAYMENT FEE IN ORDER OF $10.00 WILL CONTINUE TO ACCRUE UNTIL THE FUNDS ARE PAID IN FULL.**

HEALTH AND SAFETY:

1. I understand that all required forms must be completed and on file before my child(ren) may attend the center.
2. I understand that no child will be released to anyone except PARENT(S)/GUARDIAN(S) without written permission. I understand that the center will release the children to either parent **unless** a court order or a restraining order is provided to the center. I agree to give the center a list of all persons authorized to pick up me child(ren).
3. I understand that no medication will be administered without a **written** Medication Form signed by a **PARENT/GUARDIAN.**
4. I agree to support and reinforce the center's rules and procedures that concern the health and safety of my child(ren) and the other children enrolled in the Center.
5. I understand that the services may be terminated if my child(ren)'s behavioral patterns threaten his/her own health and safety or those of the other children or staff.
6. I understand that the Center will notify me whenever my child(ren) becomes ill, and I agree to pick-up my child(ren) as soon as possible.
7. I understand that my child(ren) cannot attend the Center if he or she has a illness that threatens the health of the other children or staff. I understand that the Health Department regulations concerning the periods of infection will be enforced. I understand that my child must be fever free for 24 hours before he/she can return to the center.
8. I understand that if my child(ren) is/are sent home because of suspected health and safety issues, I must present a doctor's note stating that my child(ren) is/are able to return to the Center. Without this statement my child(ren) will not be able to return to the Center until a note is provided.

I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND ITS APPLICATION TO MY CHILD(REN).

Parent(s)/guardian(s) Signature Date Administrator Signature Date

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Authorization for Emergency Medical Care

(Please note: This authorization must be **NOTARIZED.)**

If I cannot be contacted in an emergency situation, I authorize the staff of Word Performance Child Development Center and Academy to obtain emergency medical treatment for my child.

Name of Parent or Guardian _____

Signature of Parent or Guardian_____

Subscribed and Sworn to before me this _____ day of _____, 20_____

Notary Public _____ My commission expires_____

Identity Verification Form

OFFICIAL USE ONLY

Child's Name _____

Sex_____ Place of Birth_____

Date of Birth_____ Birth Certificate Number_____

Date Issued _____ Other Form of Proof _____

Enrollment Date _____

Withdrawal Date_____

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Photograph and / or videotape Release and Consent Form


Many of our families look forward to having their child(ren) photographed for such things as newspaper stories, school pictures, school performances, and classroom activities featuring our Child Development Center and our Academy. We are fully aware that some families require an extra degree of precaution. For this reason the Release and Consent to Photograph and/or Videotape form is necessary. This form helps us protect any of our children and their families who request that we not photograph their child(ren). Our students' safety is always our primary concern. If you have any questions about this form please, contact our administration for additional information.

I_____, hereby agree to allow my child(ren), _____

_____, to appear in photographs and or video tape taken at ***Word Performance Academy and Child Development Center.*** These photographs and /or videotapes may be used for any purpose, school or commercial (any non-profit purposes) by private companies, which have entered into an agreement with **Word Performance Academy and Child Development Center.**

_____

Signature of Parent or Guardian Date

_____

Signature of Student Date

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Tuition Agreement

To all Parents and Guardians,

At the time of your orientation and every September thereafter you will be asked to sign a tuition agreement. Please sign and return the original form to the main office. You may retain a copy for your records. Each child is enrolled for the year and **you are required to give a two week notice or pay two weeks tuition if you withdraw your child(ren) for any reason.**

If you choose to pay weekly or bi-weekly all fees and tuition payments are to be paid in full on Monday of each week. If you choose to pay monthly all fees are to be paid by the 3rd of each month. If tuition is not paid by 6:30pm on Tuesday (for monthly payments by the 4th) a $10.00 late fee will be added to your tuition payment and a $5.00 fee will be added per day until your account is paid in full.

Payments must be paid by check, money order, online or by credit card. **A 3% fee will be applied if paying by credit card.** Your child will not be accepted on Monday of the following week if tuition has not been paid in full. A $30.00 fee will be charged for each returned check.

Please refer to the Parent/Student Handbook for additional tuition information listed under:

- Absentee Policy
- Holidays
- Late Pick-ups
- Snow Policy
- Withdrawing your child/ren

My child _____ is enrolled in the _____

Program. The weekly/monthly rate for my child(ren) is $ _____

I have read the regulations stipulated in this contract, as well as the Parent/Student Handbook regarding tuition payments and procedures and I agree to adhere to all Rules and Regulations.

_____

Signature of Parent/Guardian Date

_____

Signature of Parent/Guardian Date

_____

Signature of Director/Administrator Date

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2018 - 2019 Tuition and Academic Fees

TUITION	
REGISTRATION FEE	$120.00 Annually
NOT POTTY- TRAINED	$180.00 per week
PRESCHOOL & K4 (2yrs up until school age)	$160.00 Per week
ACADEMY (Kindergarten-5th Grade)	$5,000.00 Annually ($125.00 weekly)
BEFORE AND AFTER SCHOOL (enrolled students)	$25.00 Per week
LUNCH (Academy)	$20.00 Per week
BEFORE AND AFTER SCHOOL (Non-enrolled)	$90.00 Per week
BEFORE OR AFTER SCHOOL	$70.00 Per week

UNIFORMS	
Formal	
GIRLS (NAVY PLAID JUMPER & YELLOW POLO BLOUSE)	$60.00
BOYS (Navy pants & yellow polo shirt)	$30.00
T-SHIRT & SWEATSHIRT	$30.00
Informal	
GIRLS (Khaki pants or skorts & navy polo blouse)	$25.00
BOYS (Khaki pants & navy polo shirt)	$25.00

BOOK FEES	
2 YRS. OLD	$60.00
3 YRS. OLD	$70.00
4 YRS. OLD	$120.00
KINDERGARTEN	$150.00
1st- 5th GRADE	$200.00

DISCOUNTS	
2 CHILDREN	$20.00
3 CHILDREN	$30.00
4 CHILDREN	$35.00

(Discounts are **only** for children **enrolled full time**)

AM AND PM SNACKS ARE INCLUDED IN THE TUITION RATES FOR TODDLERS AND PRESCHOOL
AM SNACK IS INCLUDED WITH ACADEMY TUITION (PM SNACK IS NOT INCLUDED)
PM SNACK IS INCLUDED WITH AFTER CARE TUITION FOR ACADEMY STUDENTS
PART TIME AND DROP IN RATES ARE AVILABLE UPON REQUEST
PRICES ARE SUBJECT TO CHANGE

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Before and After Care Rules and Regulations

Please read the following rules and regulations carefully and sign below.

1. You ***will*** respect yourself and everyone around you.
2. You ***will*** respect all property weather it belongs to you, the school or another student.
3. You ***will*** be courteous to others.
4. There ***will be no*** running inside the building.
5. Homework ***will*** be done daily. If you have no homework you must have a book to read.
6. You ***must*** ask for permission before you leave the designated area for any reason.
7. You ***will not*** verbally disrespect any other child or adult.
8. ***Some*** snacks from home will be permitted at the center's discretion.
9. You ***will not*** share snacks with other students. (This is due to the chance of food allergies)
10. You *may* need to change clothes for field trips or cooking activities.
11. You ***will*** stay inside the specified boundaries during any field trips or outdoor activities.
12. You ***will not*** damage anyone else's property.
13. You ***will*** follow all the rules that pertain to any and all playground equipment.
14. You ***will*** follow these and any other rules given to you by a teacher, administrator, or any other adult that is working or helping the staff.

If any of the rules and regulations listed above are violated the following disciplinary actions will be applied.

- ***1st warning – Written notice will be given to the parent***
- ***2nd warning – A meeting will be held with the parent and the child***

These rules and regulations will be posted for the student's convenience and as a reminder to all.

We will make every effort to ensure the safety of all students while in Before and After care. We appreciate your help and support in this matter.

I have read, understand and agree to all of the above rules and regulations along with the disciplinary actions. I also understand that they will be strictly enforced.

Student's Signature _____ Age _____ Date _____

Parent's Signature _____ Date _____

Administrator's Signature _____ Date _____

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School Bus Rules and Regulations

1. The students are expected to follow the bus driver's instructions, show respect and be obedient at all times.
2. The students are to board the bus in an orderly fashion and be seated immediately.
3. The students are to remain seated at all times while the bus is in motion.
4. The students are required to share seats equally and be courteous and respectful towards others and their property.
5. The students are required to buckle their seatbelts at all times while on the bus.
6. The students are not allowed to put any part of their body outside the bus at any time.
7. The students are required to keep the center aisle of the bus clear at all times.
8. The students are not permitted to bring large objects, food, beverages, glass or electronics on the bus unless discussed with the office staff beforehand.
9. The students are not permitted to play rough, fight, jump or run on the bus at any time.
10. The students are required to board and exit the bus in single file line.
11. The students are not permitted to push students while in line to board or exit the bus.
12. The students are not permitted to run to the bus.
13. The students are required to exit the bus one at a time, starting with the students seated in the front of the bus.
14. All book bags and belongings are to remain closed while the bus is in route.

If any of the rules and regulations listed above are violated the following disciplinary actions will be applied.

- ***1st warning – Written notice will be given to the parent***
- ***2nd warning – A meeting will be held with the parent and the child***
- ***3rd warning – Bus privileges will be suspended for one week. Parents will be responsible for transporting their child for that week***

I have read and explained these rules to my child. We understand and agree to all of the above rules and regulations along with the disciplinary actions. We also understand that these rules and regulations will be strictly enforced.

Student's Signature Date

Parent's Signature Date

Administrator's Signature Date

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EMERGENCY CARD

I give permission for word Performance Child Development Center and Academy to make whatever emergency (ie: first aid, disaster evacuation) measures are deemed necessary for the care and protection of my child while under the supervision of the staff.

In case of a medical emergency, I understand that my child will be transported to the nearest emergency unit for treatment if the emergency resource (police, rescue squad) deems it necessary.

It is understood that in some medical situations the administration or staff will need to contact the emergency resource before the parent, child's physician and/or other adult acting on the patent's behalf.

Child's Name_____

Date_____ Signature _____

Physician _____

Allergies_____

Medications and other significant Medical information_____

EMERGENCY CARD

I give permission for word Performance Child Development Center and Academy to make whatever emergency (ie: first aid, disaster evacuation) measures deemed necessary for the care and protection of my child while under the supervision of the staff.

In case of a medical emergency, I understand that my child will be transported to the nearest emergency unit for treatment if the emergency resource (police, rescue squad) deems it necessary.

It is understood that in some medical situations the administration or staff will need to contact the emergency resource before the parent, child's physician and/or other adult acting on the patent's behalf.

Child's Name_____

Date_____ Signature _____

Physician _____

Allergies_____

Medications and other significant Medical information_____

Child's Name_____Age_____

Date of birth_____ Telephone Number_____

Address_____

City _____State_____ Zip Code_____

Mother_____ Work Phone_____ Cell_____

Father_____ Work Phone_____Cell_____

ALTERNATE CONTACTS: (YOU MUST PROVIDE 2 NAMES)

Name _____Relationship_____

Address _____

Home or work Phone_____Cell Phone_____

Name _____Relationship_____

Address _____

Home or work Phone_____Cell Phone_____

Persons NOT authorized to pick up your child_____

Child's Name_____Age_____

Date of birth_____ Telephone Number_____

Address_____

City _____State_____ Zip Code_____

Mother_____ Work Phone_____ Cell_____

Father_____ Work Phone_____Cell_____

ALTERNATE CONTACTS: (YOU MUST PROVIDE 2 NAMES)

Name _____Relationship_____

Address _____

Home or work Phone_____Cell Phone_____

Name _____Relationship_____

Address _____

Home or work Phone_____Cell Phone_____

Persons NOT authorized to pick up your child_____

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: _____/_____/_____

MCH 213G reviewed 03/2014

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

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

Student's Name _____ Date of Birth: ___/___/___
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity		
*Rubella	1		Serological Confirmation of Rubella Immunity		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

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

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

Student's Name:_____ Date of Birth: [__|__|__|__]

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

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

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

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

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**[__|__|__]

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

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

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**[__|__|__]

Section III
Requirements

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight: _____ lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP _____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

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

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

TB Screening: ☐ No risk for TB infection identified ☐ No symptoms compatible with active TB disease
☐ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading ____mm TST/IGRA Result: ☐ Positive ☐ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead: _____ Hct/Hgb _____

Developmental Screen

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

Hearing Screen

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

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ Unable to test – needs rescreen
☐ Permanent Hearing Loss Previously identified: ___Left ___Right
☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

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

☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen

Dental Screen

☐ Problem Identified: Referred for treatment
☐ No Problem: Referred for prevention
☐ No Referral: Already receiving dental care

Recommendations to Child, 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:** _____