Sonshine Preschool, LLC

1817 General Booth Blvd.

Virginia Beach, VA 23454

757-721-7388

Sonshine@beachfellowship.com

Requirements:

Children must be 3, 4 or 5 years old by September 30, 2020

All required documentation must be submitted by August 27th

General Information 2020-21

PreK-3/ PreK-4/ Kindergarten Classes

September-May School Hours: 9:00am - 12:30 pm for PreK- 3

9:00am - 1:00 pm for PreK- 4

9:00am - 1:30 pm for Kindergarten

Registration and Materials Non-Refundable Fee: $175.00

Tuition Schedule:

2 Days/ Week Program: $250.00/ month

$2250.00/year

3 Days/ Week Program: $300.00/ month

$2700.00/year

5 Days/ Week Program: $375.00/ month

$3375.00/year

Kindergarten Program (5 Days Only): $450.00/ month

$4050.00/ year

There is 10% discount on years tuition paid by the end of September.

There is a 30% discount for siblings.

Sonshine Preschool Registration Form 2020-21

Please fill out **ALL** fields on this form and return to the office. Please inform the school immediately if there should be any changes on this form during the school year. **PLEASE PRINT**

Kindergarten Program_____**(Check on line)**

5-Day/Week (Monday-Friday) _____

After School Hours Needed? Yes___No___

Student's Name_____ DOB_____ AGE_____
(First) (Middle) (Last)

Mother's Name_____ Father's Name_____
(First) (Last) (First) (Last)

Legal Guardians_____/_____
(First) (Last) (First) (Last)

****If there are court documents that are necessary for child's safety, please be ready to provide any additional information, as requested.*

Address_____ Phone Numbers _____(Home#)

_____ _____(Mother's Cell #)

Email _____ _____(Father's Cell#)

ALLERGIES:_____If your student has an emergency care plan from their PCP, please notify the Director for additional information.

Emergency Contacts: In the case of an emergency, please list NO MORE THAN THREE INDIVIDUALS who you give permission to drop off and pick up your child from school. By listing these individuals, you are also giving the school permission to contact them to pick up your student when there is a failure to make immediate contact with you, the parent(s)/legal guardian(s), in an emergency and/or non-emergency situations where a child needs to be picked up during school hours.

Name	Contact #	Relationship to Child

Doctor's Name and Contact Number:_____
(Group Name)

_____
(PCP)

_____
(Office #)

Insurance Information: _____
(Type or Carrier)

_____
(ID#/Group #)

Previous School(s)Attended: _____

_____

Received and Read Handbook ____(please initial, if complete)

Signature of Parent(s) or Legal Guardian(s):_____

By signing this document, you are confirming the above information is current and valid.

Sonshine Preschool Registration, Continued

Please list any schools your child may have previously attended

Name of School	Location	Dates of Attendance

Church Membership or Affiliation:

Would you like to volunteer for special events? _____
(Events are usually during school hours)

How did you find out about our school?_____
Referred by_____

If there is anything that you think we should know or you'd like to share about your student that will help us make their school experience a great one, please feel free to let us know here.

Name(s) and Age(s)of Sibling(s)

Name	Age	Name	Age

Name and type of pet(s)

Name	Type	Name	Type

Office Use: RForm___RFee___Contract___HForm___MedR____MedF____P/V Form___IDF____Tithe.ly___

Sonshine Preschool, LLC

Registration Check List

___Registration Form

___Registration Fee

___Authorization for Emergency Treatment of Minor Child

___Medical Release Form

___Commonwealth of Virginia School Entrance Health Form (Updated information required for returning students)

___Financial Contract

___Photo/Video Release Form

___*Verification of Identity (Birth Certificate or Passport is necessary to be viewed. Do not make copies of these documents or leave them in the possession of a staff member).

*Not needed for returning students

ALL FORMS MUST BE COMPLETE AND TURNED IN BEFORE THE FIRST DAY OF SCHOOL.

ATTENTION!!!

Do not sign the attached forms. They must be notarized.

Authorization for Emergency Treatment of Minor Child

This document authorizes emergency medical treatment of the minor child (under 18 years of age) In the absence of parent(s) or legal guardian(s). The original completed and notarized copy of this form shall be presented by (or on behalf of) the minor. Use one form for each child.

THE MINOR	NAME	BIRTHDAY	SOCIAL SECURITY NUMBER

YOU	I/We the parent(s) or legal guardian(s) of the above named minor authorize emergency medical treatment by affiliated physician(s) and staff personnel and the below hospital facility throughout the specified dates and assume responsibility for all costs not covered by insurance policy.
YOU	Parent(s) or Legal Guardian(s) / Home Telephone Address
Minor's Hospitalization Coverage	Hospital Facility Closest Facility / Inclusive Dates of Authorization (If dated) From: Through: Name of Insurance Company / Policy Number_____ Group Number_____ Address Name of the Insured / Relationship to Minor Address / Social Security Number
Minor's Medical Information	Special Conditions (Allergies, ect.) Name of Physician Address / Emergency Telephone

YOUR CERTIFICATION: PLEASE SIGN BELOW IN FRONT OF Notary. Picture I.D. Required

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

_____ _____

SIGNATURE OF NOTARY **DATE**

_____

MY COMMISSION EXPIRES:

Sonshine Preschool

MEDICAL RELEASE

In the event of an emergency where medical treatment is required, I give my permission to a Sonshine Preschool Representative to obtain the services of a licensed physician. Please attempt to notify me immediately concerning any such emergency. My phone number is _____

I waive and release any and all claims for damages which I may have against Sonshine Preschool or any representative of Sonshine Preschool and I hereby agree to indemnify them against any and all claims, loss, expense or liability, that indemnities may incur as a result of any injury, harm or loss that my child may incur or sustain or any claim that my be asserted against indemnities by any third party as the result of any such injury, harm or loss.

I represent that I am a parent (guardian) of the minor, _____ , and do give my permission as stated above.

_____ _____

Parent Date

STATE OF VIRGINIA
COUNTY OF VIRGINIA BEACH

On this _____ day of _____, before me, _____
a Notary Public in and for said state personally appeared _____ known to me to be the person who executed the foregoing Medical Release.

_____ _____

Notary Public Date

My commission expires: _____

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

Part I – HEALTH INFORMATION FORM

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

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

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

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

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

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

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

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

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

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

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

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

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

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

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

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

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

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

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

_____
_____
_____.

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

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

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

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

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

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

Section III
Requirements

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

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

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

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

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

Developmental Screen

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

Hearing Screen

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

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

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

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

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

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

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

Summary of Findings (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epinephrine auto-injector □ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) **□ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/_____/_____

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

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

Sonshine Preschool, LLC

Financial Contract

Student's Name:_____

School Year: 2020-21

Payment in Full

I have payed the full years tuition in the amount of $_____

Payment Method:_____

Signature/Date_____

Tuition Installments

I,_____, agree to monthly installments to Sonshine Preschool, LLC, in the amount of $_____, which goes towards the total cost of tuition for the school year. Payments are due by the 5th of every month. If payment is received after this date, a $25.00 late fee will be applied. If paying by a personal check or money order, please make payments to: **Sonshine Preschool, LLC.** If paying with a debit or credit card, go to website and choose the pay online option and accept bank transaction fees.

Please initial the following:

____Total Monthly Payment Due is $_____on the **first school day of every month.**

____There is a **$35.00 insufficient fund fee** for all returned checks.

____Registration Fee is **Non-Refundable.**

____There is a minimum of a **two week notice** for withdrawal of the school.

____**If extended hours have been accrued** over what has been stated above, payment is due on the day of services or on the day a notice for payment is received.

By signing this contract, you (parent or guardian), agree to the terms stated above. If there are any changes or adjustments needed, the office needs to be notified immediately.

Signature/Date_____

Office Notes:

Sonshine Preschool, LLC

1817 General Booth Blvd.

Virginia Beach, VA 23454

757-721-7388

Sonshine@beachfellowship.com

Video/Photo and School Directory Release

I/We understand that my child's likeness may be **photographed or videotaped** by Sonshine Preschool in the course of school day. I/We hereby consent for the school and/or church to use our child's likeness in promotional and/or advertising materials. I affirm that I have the legal right to issue such consent.

Parent/Legal Guardian Signature:_____

Date Signed:_____

****

I hereby give permission for my name and telephone number to be released for an Emergency Phone Tree and other shared class phone lists.

Parent/Legal Guardian Signature:_____

Date Signed:_____

IDENTITY VERIFICATION FORM

The 1998 General Assembly passed legislation which affects child day centers sponsored by religious institutions. This law is intended to help identify missing children and requires the following:

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency, record from a public school in Virginia, or certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented. While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

If the requested information is not received within seven (7) business days of your child's first day of school we are bound by law to notify the local law enforcement agency.

Child's Name: _____

OFFICE USE ONLY
IDENTITY VERIFICATION

Birth Certificate Information:

Place of Birth	Birth Date	Birth Certificate Number	Date Issued

Other Forms of Identification

☐ Birth Registration Card ☐ Notification of Birth *(Hospital, physician, or midwife record)*

☐ Passport ☐ Placement agreement or proof of child's identity from a child placement agency.

☐ Public School record in Virginia ☐ Public School in U.S. *(letter from Principal)*

_____ has viewed the required information

(Signature)