BEACH

SONSHINE PRESCHOOL

Thank you for choosing Beach Fellowship's Sonshine Preschool for your child's early childhood education. We are delighted to serve you and your family. In this packet you will find all the documents required for registration. These forms need to be completed and turned in before the first day of school. Please be aware that the Medical Release and the Authorization for Emergency Treatment forms need to be signed before a Notary. Your child's birth certificate needs to be seen (not copied) before the first day of school, as well.

If you should have any questions, please feel free to email me at: beth@beachfellowship.com

We are excited for another blessed and exciting year with our students and families!

God Bless,

Beth Williams

1817 General Booth Boulevard, Virginia Beach, Virginia 23454
Phone: (757) 721-7388, Fax: (757) 721-3395

Registration Check List

Sonshine Preschool, LLC

___Registration Form

___Registration Fee

___Authorization for Emergency Treatment of Minor Child

___Medical Release Form

___Commonwealth of Virginia School Entrance Health Form

___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).

***All forms must be completed and turned in before the first day of school. Please be sure that we have all that we need to take care of your child before the first day of school.

Sonshine Preschool Registration Form 2018-19

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

Three Year Old Program _____(check on line)	Four Year Old Program_____(Check on line)
2-Day/Week (Tuesday/Thursday) _____	No 2-Day/Week Program Available for this Age
3-Day/Week (Monday, Wednesday, Friday)_____	3-Day/Week (Monday,Wednesday,Friday)_____
5-Day/Week (Monday-Friday) _____	5-Day/Week (Monday-Friday) _____
Before School_____(check on line) Days Needed_____	After School_____(check on line) Days Needed_____

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 an Epi-pen, Inhaler or Benadryl are necessary for child's wellness, please be ready to provide necessary documentation and medicine for the school. Medical documents needed are provided by Director.

Emergency Contacts: In the case of an emergency, please list all of those who you give the school permission to contact, other than parent(s) or the legal guardian(s).

(Name) (Contact #) (Relationship to Child)

(Name) (Contact#) (Relationship to Child)

(Name) (Contact#) (Relationship to Child)

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

_____
(PCP)

_____
(Office #)

Insurance Information: _____
(Type or Carrier)

_____
(ID#/Group #)

Church Membership:_____

Signature of Parent(s) or Legal Guardian(s):_____
By signing this document, you are confirming the above information is current and valid.

Office Use: RForm___RFee___Contract___HForm___MedR____MedF____P/V Form___IDF____

Sonshine Preschool, LLC

1817 General Booth Blvd.
Virginia Beach, VA 23454
757-721-7388
beth@beachfellowship.com

VIDEO/PHOTO RELEASE:

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

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

****

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

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Financial Contract

Sonshine Preschool, LLC

Student's Name_____

School Year_____

I,_____, agree to monthly payments to Sonshine Preschool, LLC, which includes tuition in the amount of $_____ and extended hour fees in the amount of $_____. Payments are due by the 5th of every month. If payment is received after this date, a $15.00 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.

Please initial the following:

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

____There is a $25.00 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.

Print Name_____

Signature_____

Date Signed_____

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: _____

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:

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:** _____