LEGACY LEARNING ACADEMY

Please complete all blanks on this form. Incomplete enrollment forms cannot be accepted.

According to the minimum standards put forth by the Commonwealth of Virginia, we are unable to care for your child until all required paperwork is submitted, including: ☐ Child's proof of identity ☐ Up-to-date shot records ☐ Up-to-date physical ☐ Medication form, if applicable

PROGRAM: ☐ Before- & After-School ☐ Before-School ☐ After-School ☐ Preschool ☐ School's Out Camp-Spring Break

CHILD'S INFORMATION:

Child's full name		Nickname	Sex	Birth date
Street address			First day of attendance	Last day of attendance
City	State	Zip	Home phone	Grade/ class level
School	Programs previously attended		Schools/programs concurrently attending	

EMERGENCY INFORMATION: If your child takes any medication, please also fill out the ☐ Medication Authorization Form.

Allergies and intolerance to food, medications or other substances and actions to take in emergency situation	
Chronic physical problems/diseases; pertinent development information; special accommodations needed; special instructions to provider	
Child's physician	Physician's phone

In the event of an emergency, please number, **in order of priority (1–6),** which phone to contact.

Parent/guardian name 1			Cell phone	Priority
Address (enter "same" if address is the same as the child's)			Email address	
City	State	Zip	Home phone	Priority
Place of employment			Work phone	Priority

Parent/guardian name 2			Cell phone	Priority
Address (enter "same" if address is the same as the child's)			Email address	
City	State	Zip	Home phone	Priority
Place of employment			Work phone	Priority

Emergency Contact 1 (if parent(s) cannot be reached)	Address			Phone
	City	State	Zip	
Emergency Contact 2 (if parent(s) cannot be reached)	Address			Phone
	City	State	Zip	
Persons authorized to pick up child (appropriate custody or other court order shall be attached if a parent is not allowed to pick up the child)				

The parent authorizes the application of hypo allergenic sunscreen/insect repellent for his or her child by LLA staff. (Please note any adverse reaction to sunscreen/insect repellent of which you may be aware.) ☐ Yes ☐ No

Parent/guardian signature (valid for one year)_____ **Date** _____

FEES AND PAYMENTS:

The Legacy Learning Academy requires that payments are due the Friday **before each week of care**. Please check your desired payment frequency below.

☐ Weekly (on Monday) ☐ Monthly

ISSUES THAT RESULT IN ADDITIONAL FEES: Please read and check each statement below.

☐ I understand that my weekly tuition is due by 6pm on the Friday before each week of care.

☐ If my payment is returned by my bank, I am responsible for a $12 returned payment fee in addition to the amount of the original payment.

☐ Payments that are returned by the bank and remain unpaid on the Sunday before the week of care begins will be assessed an additional $15 late payment fee.

☐ After a second returned payment, my care may be suspended.

☐ I understand that my child must be picked up by 6pm. I will be charged $15 for each 15-minute interval past 6pm.

OTHER FINANCIAL INFORMATION: Please read and check each statement below.

☐ **I understand that my receipts should be kept as a record for filing taxes.**

☐ LLA program sessions are not prorated, and I must register my child and pay for full sessions.

☐ Registration fees/deposits are nonrefundable.

By signing below, you are authorizing all of the above.

Signature _____ Date _____

AUTHORIZATIONS AND STATEMENTS OF UNDERSTANDING:

RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION

Permission is granted to Legacy Learning Academy to access my child's school records and contact school administrators and staff for purposes pertaining to growth, development and achievement of my child including, but not limited to: SOL Scores, Report Cards, Progress Reports, behavioral issues, homework assignments etc. I understand that access to this information will be used in possible grant writing and assisting the child in achieving his/her academic and social and emotional growth milestones.

☐ I will allow this. ☐ I choose not to allow this.

STATEMENT OF AUTHORIZATION: Please read and check each statement and sign below.

☐ My child has permission to be transported by LLA and to participate in all LLA program activities and related field trips.

☐ LLA agrees to notify me (parent/guardian) whenever my child becomes ill. I agree to pick up the child within 30 minutes of receiving the call that my child is ill. **(A temperature of over 100°F, recurring vomiting/diarrhea or a communicable disease would require exclusion from the YMCA.)**

☐ I (parent/guardian) authorize LLA to obtain immediate care if any emergency occurs when I (parent/guardian) cannot be located immediately. I understand that in an emergency, my child may be transported in a private vehicle.

☐ I agree to inform LLA childcare staff/director within 24 hours or the next business day if my child or any other immediate household member has developed any reportable communicable disease, as defined by the State Board of Health, except for life-threatening diseases which must be reported immediately.

☐ I have been informed of my LLA Child Care program's Emergency Preparedness Plan.

STATEMENT OF UNDERSTANDING:

The following information is important for the safety and protection of your child. Please read this information and sign below.

- I understand that I am not to leave my child at the LLA program site unless an LLA Child Care staff member or volunteer is there to receive and supervise my child.
- I understand that it is my responsibility to sign my child in upon arrival in the morning and sign my child out before leaving in the afternoon. **Sign-in/sign-out sheets are available as you enter the program. There must be an exchange of responsibility from one adult to another, not from a child to staff. All persons signing children in/out must be at least 16 years of age.**
- I understand that my child will not be allowed to leave the program with an unauthorized person. **Any person authorized to pick up my child must be listed on this form. Authorization by telephone will not be accepted.**
- I understand that LLA staff and volunteers are not allowed to babysit or transport children at any time outside the LLA facilities and program. **If a violation of this policy is discovered, LLA will take immediate disciplinary action toward staff and volunteers.**
- I understand that by state law, LLA is mandated to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I consent for the use of photographs or digital images of my child in any printed/filmed material for promotions of LLA.
- I am an adult over 18 years and wish to have my child participate in LLA Child Care programs. I understand that even when every reasonable precaution is taken, accidents can sometimes happen. Therefore, in exchange for allowing my child to participate in LLA Child Care, I understand and expressly acknowledge that I, for myself and for anyone entitled to act on my behalf, waive and release LLA, sponsors, representatives and successors from all claims or liabilities of any kind arising out of my participation in activities at or sponsored by LLA. I further agree to indemnify and save harmless LLA from any claims or demands arising out of any such injuries or losses. I understand that this release includes any claims based on negligence, action or inaction of LLA, its staff, directors, members and guests. I have read, understand and am voluntarily signing this authorization and release.

☐ I have read and understand the statements above regarding LLA policies and procedures.

☐ I have received a copy of the LLA Parent Handbook.

☐ I have provided a copy of my child's physical and immunization records along with this form.

☐ I have read and understand the statement above regarding the Model Release.

Signature _____ Date _____

CHILD'S NAME: _____

CHILD'S PROOF OF IDENTITY:

The Code of Virginia states that "Proof of identity means a certified copy of a birth certificate or other reliable proof of the child's identity and age. The following documents are acceptable forms of reliable proof. Please check which document you are submitting.

- ☐ Certified copy of birth certificate
- ☐ Birth registration card
- ☐ Notification of birth (hospital, physician or midwife record)
- ☐ Passport
- ☐ Copy of placement agreement or entrustment agreement from a child placing agency (foster care and adoption agencies)
- ☐ Record from a public school in Virginia
- ☐ Certification by a principal or his designee in the US that a certified copy of the child's birth record was previously presented
- ☐ Copy of the conferring temporary legal custody or entrustment agreement of a child to an independent foster parent
- ☐ Child identification card issued by the Virginia Department of Motor Vehicles (DMV)

For Office Use Only

Form of Identity Verification	Date of Birth	Place of Birth	Start Date	End Date
Document Number	Date Issued	Staff Signature		

Medication Authorization Form

For Prescription and Non-prescription (OTC) Medication

INSTRUCTIONS:

- Section A & C must be completed by the parent/guardian for ALL medication being authorized.
- Section B must be completed by a physician for any medication authorizations. This includes non-prescription medications.
- Each medication needs a separate authorization form. Multiple medications cannot be listed on one form.
- If diagnosed with asthma an inhaler with chamber and mask along with a separate action plan must accompany this document
- If an Epipen is prescribed, a separate action plan must accompany this document
- If the end date documented by the physician expires before school is out for the year, a new authorization form will be required.

SECTION A: To be completed by parent/guardian

Child's first and last name
Child's known allergies

SECTION B: To be completed by child's physician

I,_____order the medication listed to be administered.		
Name of medication		Strength
Dosage	Times to be given	Frequency
Reason the child is taking this medication (unless confidential by law)		
Describe any additional training, procedures or competencies the child's program staff will need to know.		
This authorization is effective from:_____(start date) until _____(end date)		
Physician's signature		
Date:	Physician's phone number:	

SECTION C: To be completed by parent/guardian

I,_____(parent's name) authorize_____(program name) to administer this medication as specified in this medication form.	
Parent' signature	Date

Legacy Learning Academy

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

Legacy Learning Academy

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:** _____