Grace Preschool

"A Tradition in Creating Bright Futures"

Dear Prospective Family,

Thank you for your recent inquiry about our school. We are in the process of planning for another successful year and I am happy to send you information on our program. Enclosed, please find the registration form, health and immunization form, emergency card, andscheduleoffees.Wewillalsoneeda copyofyourchild'sbirth certificate and can make the copy for you when you drop off the completed forms.

During the summer months, tours can be arranged by calling the church office at 420-4704. The school office will be staffed from the last week of August through the end of May, so feel free to call me with any questions or to schedule a visit. I look forward to meeting you and your child.

Sincerely,

Mihaela Guy

521 Providence Road, Chesapeake, VA 23325
757-420-4720
preschool@GraceLutheranChesapeake.org
www.GracePreschoolChesapeake.weebly.com

FEES FOR THE SCHOOL YEAR 2019 - 2020

Non-refundable Registration and Supply Fee	**$110.00**
Early Registration and Supply Fee ends March 30, 2019	**$95.00**

---

5 day per week program available for 3's and 4's	$235.00 per month
3 day per week program available for 3's and 4's	$190.00 per month
2 day per week program available for 2's only	$160.00 per month
3 day per week program available for 2s only	$200.00 per month

Lunch Bunch offered Tuesdays and Wednesdays from 12 to 1:30 for $7/day

---

Monthly tuition is due the 1st of the month. A late payment fee of $10.00 is charged after the 10th.

A 5% discount is given for any family that prepays for the entire year.

A 10% discount is given for the second child in the same family if both children attend the 5 day per week program.

There is a $25.00 returned check fee

REGISTRATION FORM

A. Name_____ Sex___ DOB_____
Last First Middle

Please check one of the following:
2 year old program ___ **or** 3 year old program___ # of days___ **or** Pre-K____ # of days____

B. Registering Adult_____ Home Phone_____

Address_____

Email Address_____ Cell Phone_____

Social Security #_____ Relationship to Child_____

Place of Employment_____ Work Phone_____

C. Other Adult in Home_____

Social Security #_____ Relationship to Child_____

Place of Employment_____ Work Phone_____

D. List all other household members_____

_____

E. Child's Physician_____ Phone_____

F. Name and phone # of person(s) to be contacted in case of emergency when you cannot be reached.
Please do not list anyone who is working or lives out of town.

1._____
Name Phone Relationship to Child
2._____
Name Phone Relationship to Child

G. Name and phone # of person(s) authorized to pick up your child from school.

1._____
Name Phone Relationship to Child
2._____
Name Phone Relationship to Child

H. Does your child take any medications regularly? If so, which ones_____

_____

List all allergies _____

_____

I. Please tell us a little something about your child.
Words used for bathroom, special likes or dislikes, any unusual habits and anything else we should know to help him/her feel at ease.

_____

_____

Are there any special difficulties such as allergies, physical handicaps or any condition that could affect your child in school? _____

Is your child right or left-handed?
_____

What are your child's favorite activities? _____

J. Circle the proper choice:

1. Number of different children your child plays with regularly: Over 10 5 - 10 Less
2. Child controls his anger: At all times Fairly Well Not at all
3. Child is able to dress and undress: Completely alone With help Not at all
4. Child's muscular coordination: Excellent Good Fair Poor
5. Child's language ability: Excellent Good Fair Poor

K. Admission Policy

No discrimination in admission or in determination of enrollment will be made for race, creed, color, sex, national or ethnic origin.
In the event of a physical handicap or chronic illness, admission to Grace Preschool will be predicated by the following: 1. Advice by the child's doctor. 2. The safety and ability of the child to participate in activities . 3. Staff capabilities. In these instances, the decision for admission will be made by the School Board in consultation with the Director. Other considerations are set by local and state regulations and the School Board as to the number of students in each class.
Prior to admission, the child and a parent/guardian must visit the preschool and meet with the director and/or the teacher.

L. Parent Authorization

My child has permission to participate in all school activities except as noted by me.

In the event I cannot be reached, I give my permission to secure emergency medical treatment for my child_____.

Parent Signature_____Date_____

STATEMENT OF AGREEMENT

I, the undersigned, acknowledge that I have read and understand the information contained in the registration packet and the handbook.

I acknowledge that I am familiar with the premises of Grace Preschool and the playground area.

I agree to pay the prescribed registration fee, the supply fee and the monthly tuition fee.

I grant permission for my child to participate in all activities and in the use of school equipment.

I give my permission for my child to participate in neighborhood walks and any and all field trips. I understand that I will be informed of all field trips and that I may withdraw my permission for a planned field trip if so desired. All field trips will be taken in private vehicles.

I grant permission for my child to be included in pictures and give permission for those pictures to be used by the school.

In the event of illness or infectious disease, I will not bring my child(ren) to school. I agree to keep my child(ren) out of school for 24 hours after all symptoms have ceased.

I understand that I or a designated emergency contact person will pick up my child immediately after being contacted if my child(ren) becomes ill.

In the event of a medical emergency and in the event that I cannot be reached, I authorize Grace Preschool to obtain emergency medical care as may be needed and agree to pay for the expense.

I will comply with the regulations and herewith release the church, school, its staff and the school board from all legal liability that might arise as a result of acceptance of your child as a student.

A finance charge of 1.5% per month (18% annum) shall be imposed upon the outstanding balance on the account or not paid in full within 30 days of the date of billing. In the event this account is referred for collection to an attorney, the parent or guardian agrees to pay or cause to be paid attorney's fees of 25% of principal amount due and owing at the time of such referral together with all cost of collections, including but not limited to, court costs, filing fees, service fees, and such enforcement of judgment rendered by a court of competent jurisdiction.

I agree to pay a $10.00 late payment fee and a $25.00 returned check fee.

I understand by signing below that I have received, read and agree to abide by the rules and regulations as stated in the school handbook and as set forth by the school board.

_____	_____
Child's Name	**Parent/Guardian**
_____	_____
Witness	**Date**

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

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:** _____

Parent email_____

Child's name_____DOB_____

Address_____

Mother's Name_____Home #_____Work #_____Cell #_____
Father's Name_____Home#_____Work#_____Cell #_____
Emergency Name_____Home#_____Work#_____Cell #_____
Emergency Name_____Home#_____Work#_____Cell #_____
Name of Adults Authorized to pick up my children:
Name_____Name_____
Name_____Name_____
PLEASE DO NOT RELEASE MY CHILDREN TO THE FOLLOWING:
Name_____Name_____
List all allergies, intolerance to food, medication or other substances:

_____
Physician's Name_____Phone #_____
This health history is correct as far as I know, and my child has permission to participate in all activities, except as noted by me. In the event I cannot be reached in an emergency, I give my permission to the physician named, or, if not available, to the physician selected by the adult in charge, to secure proper treatment for the child named above.
Signature_____Date_____

Parent/Guardian Media Recording Release for Children and Dependents

I, Parent/Legal Guardian of *(child's name)*_____hereby grant permission to Grace Preschool and its assigns and licensees to take photographs or videos of the above named minor child, and to make recordings of the above named minor voice as indicated below*: (Please check one choice in the blank.)*

____I DENY permission to GP to use my child's image or voice in any manner incl on Facebook.

____I GRANT permission for GP to use my child's image and voice recordings in print, video or for TV

By GRANTING permission as directed above, I am giving Grace Preschool permission to use these images, videos, and recordings as follows:

- The use may include reproduction, distribution including posts of public media such as Facebook, derivative works, display, and performance, both private and public.
- The use may be in composite or modified forms and in any media, now known or later developed, including without limitation newspapers, television, radio, the World Wide Web, and social media.
- The use may be for anypurpose throughout the world and in perpetuity, including, without limitation, education, trade, advertising, and promotion.

I further acknowledge that I will not be compensated for these uses, and that GP exclusively owns all rights to the images, videos, and recordings, and to any derivative works created from them.

I waive the right to inspect or approve the uses of any printed or electronic copy. I hereby release GP and its assigns and licensees from any claims that may arise from these uses, including without limitation claims of defamation or invasion of privacy, or of infringement of moral rights or rights of publicity or copyright.
GP is not obligated to use any of the rights granted under this Release. This

Release expresses the complete understanding of the parties.

Name (print): _____

Address: _____

Phone:_____Cell/other phone: _____

Signature:_____Date: _____