VISION MONTESSORI™

Application for Admission

Please return this form with a non-refundable $150.00 Application Fee.

Child's Name _____ Birth date_____ Age____

Enrollment (start date) _____ Gender: M ___ F___

Half Day____ Full Day____ Extended Day ____ Tuition _____

FAMILY INFORMATION

Mother / Guardian's Name_____

Home Address: Street_____

City_____ State_____ Zip_____

Home Phone #_____Cell#_____Work#_____

Occupation _____ Email Address:_____

Employer Address:_____

Father / Guardian's Name_____

Home Address: Street_____

City_____ State_____ Zip_____

Home Phone #_____Cell#_____Work#_____

Occupation _____ Email Address:_____

Employer Address:_____

Does your child have any medical or special education needs that we should be aware of?

If yes, please list: _____

Does your child take any medications? Please list:

_____

Have there been any changes in your family or home life recently that have affected your child?

_____

Please provide any aadditional information about your child that may assist us:

_____

EMERGENCY CARE INFORMATION

Child's Doctor: _____ Office Phone #: _____

Hospital Preference: _____ Phone #: _____

Medical Insurance Provider _____ Policy# _____

In the event of the need for emergency medical care and the parent, guardian or family physician ccannot be immediately contacted; I authorize the staff of Vision Montessori to seek the medical facility or physician of their choice to provide. Emergency care.

Signature: _____ Date: _____

EMERGENCY CONTACTS: *Must have full addresses and phone numbers.*

(People who can be called in the event we cannot reach you)

1. Name_____ Home Phone #_____ Cell#_____

Address: _____ City_____ State____ Zip_____

2. Name_____ Home Phone # _____ Cell#_____

Address: _____ City_____ State_ Zip_____

Signed_____ Date_____

Signed_____ Date_____

ADDITIONAL PERSONS AUTHORIZED TO DROP OFF OR PICK UP YOUR CHILD

1. Name:_____ Home Phone # _____ Cell #_____

Driver's License #_____

2. Name:_____ Home Phone # _____ Cell #_____

Driver's License #_____

Child's Emergency Medical Authorization

Name of Child_____ Birth date_____

Name of Parent(s) or Guardian_____

Home Address_____ Telephone #_____

Place of Mother's Employment_____Telephone #_____

Address_____ Cell #_____

Place of Father's Employment_____ Telephone #_____

Address_____ Cell # _____

The Parent(s)/guardian authorizes **Vision Montessori** to obtain immediate. medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or a administration of drugs to, his/her child or ward if an emergency occurs when he/she ccannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified. immediately.

VISION MONTESSORI™

Consent & Release

For film, photos, videotape, internet, as well as any other form of electronic or digital communication.

On various occasions, your child may be photographed while at Vision Montessori. These photographs may be used by Vision Montessori and or its affiliated companies, in program planning and/or public relations. They also may be used in various types of advertising or by public television, newspapers, magazines, electronic or digital communication.

For this reason, we request that each parent sign the following release:

I hereby give or do not give Vision Montessori and its agents, the absolute right and permission to copyright and/or publish, or use with photographic portraits or pictures of my child or reproductions thereof in color or otherwise, made through any media for art, advertising, trade, electronic or digital communication or any other lawful purpose whatsoever. These pictures may be used in conjunction with his/her own fictitious name.

Name of child _____

____ No, I do not grant full permission.

____ Yes, I do grant permission.

____ Yes, I grant permission for internal use only: i.e. bulletin boards, newsletters.

Parent Name: _____

Signature: _____ Date: _____

Center Director: _____

Signature: _____ Date: _____

VISION MONTESSORI™

Infection Control Policy

It is inevitable that children will get sick, no matter where they are. As children begin to have contact with the world outside that of their own families, they are exposed to viruses and bacteria that are foreign to their bodies. This is the way they build immunities. We cannot, nor would we want to, shield a child completely from the outside world. If we did, the natural immunities a child gains through contact with others would not develop and a simple cold could become a serious illness. However, we do want to protect a child from an unusually high exposure to germs all at once.

In a child care setting, children come into contact with groups of other children outside their families. It is in this situation that the illness of one child can spread rapidly through the group to other children and staff members if stringent measures to prevent this spread are not taken.

For this reason, the staff at Vision Montessori will take constant precautions to prevent the spread of disease. Many common childhood diseases are contagious. They are caused by germs which may be spread in several ways. Intestinal tract infections are spread through stools. Respiratory tract infections are spread through coughs, sneezes, and runny noses. Other diseases are spread through direct contact. Careful handwashing by staff and children can eliminate approximately 75 percent of the risk of spreading these illnesses. Other precautions include separating sick children from those who are well, taking extra precautions with diapering or toilet training children, and working to maintain sanitary conditions throughout the center.

You, the parents, can help us in our effort to keep your children healthy. We ask your cooperation in the following ways:

1. If your child has been exposed to any of the diseases listed on the accompanying chart, we ask that you notify us of the exposure.

2. If your child shows any of the following symptoms you will be called and asked to come immediately. Please help us protect the other children by responding promptly. If your child has any of the following symptoms at home, we ask that you keep him/her out of school until the symptoms are gone or until your physician says it is all right to return.

The symptoms include:

- ✓ fever greater than 101°F.
- ✓ severe coughing - child gets red or blue in the face.
- ✓ high-pitched croupy or whooping sounds after coughing.
- ✓ difficult or rapid breathing - especially in infants
- ✓ yellowish skin or eyes
- ✓ pinkeye - tears, redness of eyelid lining, followed by swelling and discharge of pus.
- ✓ unusual spots or rashes
- ✓ sore throat or trouble swallowing
- ✓ infected skin patches
- ✓ crusty, bright yellow, dry, or gummy areas of skin - possibly accompanied by fever.

- ✓ unusually dark, tea colored urine - especially with a fever
- ✓ grey or white stool
- ✓ headache and stiff neck
- ✓ vomiting
- ✓ severe itching of body or scalp or scratching of scalp

If any of the above symptoms are present or if a child appears cranky or less active than usual, cries more than usual, or just seems generally unwell at home, you are asked to look for any of the above symptoms or inform the child's teacher so that the child can be watched carefully for the development of symptoms.

It is imperative that we all work together to keep all of the children who attend the center as healthy and happy as possible. We thank you for your cooperation.

I have read and understand the attached infection control policies, and I agree to abide by them for the protection of my child as well as the other children and staff members at Center.

Name of Child: _____

Date Signature of Parent or Guardian: _____

The infection control policies and procedures have been presented and explained to

Parent/Guardian of _____

by Staff Member_____ Date _____

Signature of Staff Member _____

VISION MONTESSORI™

Tuition Agreement

I agree to the following tuition payment plan:

Application Fee:	$	150.00
One Month's Tuition Deposit:	$	_____
First Month's Tuition:	$	_____
TOTAL:	$	_____

Your Monthly tuition payment will be: $_____

This agreement is made between Vision Montessori and:

Child/Children's Name_____

Parent/Guardian's Name_____

With receipt of your Application for Admissions, VM will initiate staffing requirements/ratios for compliance. In the event the school has a waiting list, enrollment date will be scheduled at the earliest available openings. **For this reason all fees and tuition deposits are non-refundable.**

The one month's tuition deposit will roll over year to year upon enrollment and be credited toward the last month's tuition with a 30 day advance, written notification. To secure your child's space in the school, all fees must be received within 30 days of your child's application. We accept applications year-round, on a rolling admissions and space available basis.

I accept and agree to the terms of enrollment:

Signature_____ Date_____

VISION MONTESSORI™

Sunscreen Permission Form

Name of Child: _____

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission to the staff at Vision Montessori to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he/she will be playing outside, especially during the months of May through October and between the times of 12pm and 4pm. I have provided, as specified below, when he/she will be playing outside. I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have provided the following brand/type of sunscreen for use for my child:

_____

Any known allergies your child has to sunscreen?

____ Yes ____ No If yes, please explain. _____

_____

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature:

_____

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**

Other **1** **2** **3** accordance with the **4** **5** ttending school, child

MINI

I certify that this child is **ADEQUATELY OR AGE APPROPRIATE** **Y IMMUNIZED** in MUM requirements for a

*** Required vaccine**care or preschool prescribed b *ns for the Immunizatic Children* Section III).
State Board of Health's *School* (Reference

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

Certification of Immunization 11/06

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 Examinat

1 = Within norm
=
Abnormal finding 3 = Refer
red for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT			☐	Neurological	☐	☐					
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Skin	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Genital	☐	☐	☐
	☐	☐					☐	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:** _____

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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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