



**OLD DOMINION UNIVERSITY**  
 DARDEN COLLEGE OF EDUCATION  
 CHILD DEVELOPMENT AND CHILD STUDY CENTERS

**Registration Form  
 2020-2021**

Child's Name	Nickname	Date of Birth	Sex
Street Address	City, State	Zip	Home Phone
Previous Preschool/Child Care Programs Attended/ Other Programs Currently Attending	email addresses:		
Health Concerns/Special Needs			

I do not want to be included in the CDC/CSC directory.

**Parent/Guardian Information**

Father/Guardian	Place of Employment	Business Phone
Home Address	City, State	Zip
		Home Phone and Cell Phone
Mother/Guardian	Place of Employment	Business Phone
Home Address	City, State	Zip
		Home Phone and Cell Phone

**Emergency Information**

**Full address with city, state and zip code plus phone required! Please use local contacts in the event you are unable to pick up your child.**

Child's Physician	Phone
Allergies/ Health Concerns and Action To Take in an Emergency	
Emergency Contacts (if Parents/Guardians cannot be reached)	Address
1.	Phone
2.	Address
	Phone
Person(s) Authorized to Pick Up Child	
Person(s) <b>NOT</b> Authorized to Pick Up Child*	

**Agreements**

Initial	1. The Child Development/Child Study Center agrees to notify me whenever my child becomes ill and I will arrange to have the child picked up as soon as possible.
Initial	2. I authorize the Child Development/Child Study Center to obtain immediate medical care if an emergency occurs and I cannot be located immediately. I will not hold ODU or the Child Development/Child Study Center financially responsible for the emergency care or transportation of my child.
Initial	3. I agree to inform the Child Development/Child Study Center within 24 hours or the next business after my child or any member of the immediate household has developed a reportable communicable disease, as defined by the Virginia Board of Health, except for life threatening diseases which must be reported immediately.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

Signature of Director \_\_\_\_\_

Date Child Entered Care \_\_\_\_\_ Date Left Care \_\_\_\_\_

**Identity Verification**

<b>Place of Birth</b>	<b>Birth Date</b>	<b>Birth Certificate Number</b>	<b>Date Issued</b>
<b>Other Form or Proof</b>		<b>Date Documentation Viewed</b>	<b>Person Viewing Documentation</b>

**Date of Notification of Local Law-Enforcement Agency (when required proof is not provided).**

**Date:**

**Notified by:**

Proof of child's identity and age may include a certified copy of the child's birth certificate, birth registration card, passport or other proof of child's identity from a child placement agency. While programs are not required to keep the proof of a child's identity, documentation of viewing of this information must be maintained for each child.

**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: \_

Student's Date of Birth:      Last                      First                      Middle  
    /       /                      State or Country of Birth:                      Main Language Spoken: \_\_\_\_\_

Student's Address: \_                      City: \_                      State: \_\_\_\_\_                      Zip: \_\_\_\_\_

Name of Mother or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - - - - - Work or Cell: \_\_\_\_\_ - - -

Name of Father or Legal Guardian: \_\_\_\_\_ 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 or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, 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 213

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM**

**Part II - Certification of Immunization**

*Section I*

**To be completed by a physician, 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 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 (6 <sup>th</sup> 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 <2 years 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) <input type="checkbox"/> 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* (Minimum requirements are listed in Section III).

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Section II**  
**Conditional Enrollment and Exemptions**

**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**

**\*Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- 3 DTP or DTaP – at least one dose of DTaP or DTP after 4<sup>th</sup> birthday unless received 6 doses before 4<sup>th</sup> birthday
- Tdap – booster required for entry into 6<sup>th</sup> grade if at least 5 years since last tetanus-containing vaccine
- 3 Polio – at least one dose after 4<sup>th</sup> birthday unless received 4 doses of all OPV or all IPV prior to 4<sup>th</sup> birthday
- Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- Pneumococcal – 2-4 doses, depending on age at 1<sup>st</sup> dose for children up to 2 years of age only
- 2 Measles – 1<sup>st</sup> dose on/after 12 months of age; 2<sup>nd</sup> dose prior to entering kindergarten
- 1 Mumps – on/after 12 months of age
- 1 Rubella - on/after 12 months of age

Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1<sup>st</sup> dose on/after 12 months of age; 2<sup>nd</sup> dose prior to entering kindergarten

- Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

**\* Additional Immunizations Required at Entry into 6<sup>th</sup> Grade**

- Tdap – booster required for entry into 6<sup>th</sup> grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at  
<http://www.vdh.virginia.gov/epidemiology/immunization>

Certification of Immunization 04/07

**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](http://www.vahealth.org/schoolhealth)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ Age / gender appropriate history completed Anticipatory guidance provided <b>TB Risk Assessment:</b> <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	<b>Physical Examination</b>  1 = Within normal treatment    2 = Abnormal finding    3 = Referred for evaluation or treatment  <table style="width:100%; border:none;"> <tr> <td style="width:33%;"></td> <td style="width:33%; text-align:center;">1   2   3</td> <td style="width:33%;"></td> <td style="width:33%; text-align:center;">1   2   3</td> <td style="width:33%;"></td> <td style="width:33%; text-align:center;">1   2   3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Neuro ogic</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Ski</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>		1   2   3		1   2   3		1   2   3	HEENT	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neuro ogic	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ski	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Lungs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abdomen	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Genital	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Extremities	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Urinary	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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<b>EPSTD Screens <u>Required</u> for Head Start – include specific results and date:</b> Blood Lead: _____ Hct/Hgb _____																										

	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
<b>Developmental Screen</b>	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.  <input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> <b>Unable to test – needs rescreen</b> <input type="checkbox"/> Permanent Hearing Loss Previously identified:    ___Left    ___Right <input type="checkbox"/> Hearing aid or other assistive device
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<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)  <input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> <b>Unable to test – needs rescreen</b>	<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings</b> (check one): <input type="checkbox"/> <b>Well child; no conditions identified of concern to school program activities</b> <input type="checkbox"/> <b>Conditions identified that are important to schooling or physical activity</b> (complete sections below and/or explain here): _____ _____ _____ _____ <b>Allergy</b> <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____ <input type="checkbox"/> <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc) <input type="checkbox"/> <b>Restricted Activity</b> Specify: _____ <input type="checkbox"/> <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____ <input type="checkbox"/> <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school. <input type="checkbox"/> <b>Special Diet</b> Specify: _____ <input type="checkbox"/> <b>Special Needs</b> Specify: _____ Other Comments: _____
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<b>Health Care Professional's Certification</b> (Write legibly or stamp):	
Name: _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____



**OLD DOMINION UNIVERSITY**

CHILDREN'S LEARNING AND RESEARCH CENTER

I D E A FUSION

## Emergency Medical Authorization

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Parent or Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Mother' Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

I authorize the Old Dominion University Child Development and Child Study Centers to obtain immediate medical care in the event of an emergency and I cannot be located immediately. I agree to indemnify and hold the University harmless for any expenses of treatment or transportation of my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Medical Insurance Information:

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_

List chronic physical problems, developmental information, special accommodations, allergies to food or medication, dietary restrictions and action to be taken in an emergency situation.

I understand and agree to the following:

1. Program hours are 7:30 a.m. to 5:30 p.m.
2. Late pick-up charges are \$10.00 for the first ten minutes or any part of, and an additional \$1.00 per minute after the first ten minutes. After 30 minutes, we will contact emergency contacts to pick-up your child.
3. The CLRC is a "Nut Free Zone". No peanut or tree nut products will be served or brought in by parents.
4. I authorize the ODU CLRC to obtain immediate medical care in the event of an emergency and I cannot be located immediately. I will not hold Old Dominion University or the Children's Learning and Research Center financially responsible for the emergency care or transportation of my child.
5. Only prescription medication with proper documentation from a physician will be administered in the CLRC. I understand the CLRC staff will not apply sunscreen, bug spray, lip balm, or lotion.
6. If my child becomes ill, I will be called to pick them up immediately. Children must be fever and symptom free for 24 hours and be able to comfortably participate in the daily activities before returning to the CLRC after illness.
7. I will notify the CLRC within 24 hours or the next business day if any member of my immediate household has developed any reportable communicable disease, as defined by the VA State Health Department. Life threatening diseases will be reported immediately.
8. Tuition payments are due on the 5<sup>th</sup> of each month. On the 10<sup>th</sup> of the month, a \$20 late fee will be added. Accounts 30 days past due will be sent to collections.
9. I will give a 30 day written notice, including a reason, should I choose to withdraw my child from the CLRC. Tuition will be due for those 30 days.
10. I have read the ODU Children's Learning and Research Center Parent Handbook and agree with the policies contained in it.

Child's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_





# OLD DOMINION UNIVERSITY

CHILDREN'S LEARNING AND RESEARCH CENTER

IDEA FUSION

## ODU CLRC Full Day Program Tuition Agreement 2020-2021

Please fill out one form per child.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent Name \_\_\_\_\_ S.S.N. \_\_\_\_\_

Effective 8/1/2017	Weekly (paid 52 weeks)		Monthly (paid 12 months)	
	ODU Full-Time Faculty/Staff and Current Students	Community Members	ODU Full-Time Faculty/Staff and Current Students	Community Members
CLRC is open 49 weeks per year				
Infants (8 weeks – 15 months)	\$230	\$240	\$996	\$1039
Toddlers (16 months – 2 years)	\$206	\$217	\$892	\$938
Preschool (3, 4, & 5 years)	\$202	\$209	\$872	\$904

Parent Name \_\_\_\_\_ S.S.N. \_\_\_\_\_

I will pay: \_\_\_\_\_ weekly \_\_\_\_\_ monthly.

I certify I am: \_\_\_\_\_ ODU Full-time Faculty or Staff UIN \_\_\_\_\_

\_\_\_\_\_ Current ODU Student UIN \_\_\_\_\_

Total Monthly Tuition: \_\_\_\_\_ or Total Weekly Tuition: \_\_\_\_\_

I agree to pay the monthly or weekly tuition stated above. I understand the tuition is due no later than the 5th of each month. Payments must be made in Center 1 or 2. Payments made after the 10th of the month will incur a \$20.00 late fee. Should I need to withdraw my child from the program, I will give 30 days' written notice including the reason for leaving the program. Tuition will be due for those 30 days. Should my status with the university change, I understand that I am liable for the new tuition rate from the date of change. I understand that there will be no deductions for vacation, illnesses, holidays or other days the center may be closed.

Signed \_\_\_\_\_

Date \_\_\_\_\_



**OLD DOMINION UNIVERSITY**

DARDEN COLLEGE OF EDUCATION

CHILD DEVELOPMENT AND CHILD STUDY CENTERS

## USDA Participation

The Child Development Center is participating in the USDA Food Reimbursement Program for childcare centers. This program reimburses the Center a small amount for each lunch and snack provided to children. Please fill out the information below so we can document it for the reimbursement program for childcare centers.

As a participant in the USDA Child and Adult Care Food Program, the Center will provide the following meals and snack for your child, according to the meal pattern chart on the enclosed "Building for the Future" flyer;

- Breakfast
- Lunch
- PM Snack

Infants will be provided with one brand of iron-fortified infant formula. The Center will also provide solid foods for an infant when they are over 6 months and developmentally ready for it.

Days & Hours of Care (circle all that apply): M T W T F

Time dropped off \_\_\_\_\_ picked up \_\_\_\_\_

Child's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Sick Child Policy

Our intention is to make every effort to insure the health of your child. For this reason, the following guidelines regarding health practices have been established. All Center staff have been trained in matters regarding childhood illnesses and health and safety practices. Please keep your child home when he/she has a fever, diarrhea, rash, vomiting, discharge from the eyes or green discharge from the nose. Not only is your child contagious, but his resistance is down and he could get sicker. Child should be fever and symptom free for 24 hours without medication before returning to school. At arrival each day, attention will be given to each child's state of health to decrease the possibility of infection being transmitted. If a child should become ill while at the Center, he or she will be removed from the classroom. At that point, the child's parent will be called and the parent will pick up the child within one hour.

If your child has been free of symptoms for 24 hours but still is in need of medication, Center staff will dispense medication according to the following guidelines. Parent/guardian's will be required to fill out a Medical Form with instructions on the time and amount of medication to be dispensed. This form must be filled out and signed each day that medication is to be administered.

- No non-prescription/or over the counter medication can be given by Center Staff
- All prescription medication shall be in the original bottle labeled with the child's name, the name of the medication, the dosage amount, and the time to be given.
- All medication will be kept in a locked container.
- Sun screen needs to be applied prior to coming to school (as needed).
- Bug repellent needs to be applied prior to coming to school (as needed).
- Every year parents will be asked to read and sign the policy book.
- The Center will be required to keep a record of this information.

I have read the description of the ODU Child Development Center's Sick Child Policy and agree to the terms outlined.

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Child's Name

---

Parent's Signature

---

Date



**OLD DOMINION UNIVERSITY**  
DARDEN COLLEGE OF EDUCATION  
CHILD DEVELOPMENT AND CHILD STUDY CENTERS

## Performance and Participation Release for University Programs

As a laboratory school, enrolled children at the Child Development and Study Centers may participate in training activities for undergraduate and graduate students at Old Dominion University majoring in Early Childhood Education, Special Education, and Communicative Disorders, as well as other disciplines throughout the University. Qualified faculty members approve and supervise any videotaping, filming, testing, case discussion or presentations where there are children involved. Specific parental permission will always be requested for approved research projects or individual projects with children.

I understand that my child, \_\_\_\_\_ will be participating in activities described above and give my permission for participation.

I also authorize Old Dominion University, without restrictions of any kind, to use my child's photographic likeness, and voice, singly or in combination, in a motion picture, television tape recording, photographic image, digital image, or series of such productions to be produced by ODU and to be distributed and exhibited by means of television broadcasting or cable, the internet, print, or by any other means of distribution of exhibition. Photos, videotaping, recordings or other images used for any other occurrence or intended use will require separate specific permission. I agree that no monetary compensation is implied or expected from this release.

Child's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Parents Name (printed) \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

# **IMPORTANT!**

## **Nut Free Zone Policy**

The Child Development Center and Child Study Centers are “Nut Free Zones”. We will not serve peanut butter or other products that are derived from peanuts or tree nuts (almonds, cashews, walnuts, pecans, etc.) in our programs. We request that you not send any food items to us that contain any of these items. A child with a severe allergy to nuts is at great risk of a life-threatening reaction should they be exposed to the nuts or their oils. In an effort to ensure the safety of all children in our program, we will strictly adhere to this policy. As always, children will wash their hands before and after lunch. We will also ask children to wash their hands when they arrive in the morning, in order to minimize any risks. I know you will be understanding and cooperative with this very important policy that we must implement in order to ensure a safe and healthy environment for all of our children.

At the beginning of the school year, I will send home additional information about this policy. Should you have any questions, please feel free to contact me at 683-3081 or by e-mail at [kwilliam@odu.edu](mailto:kwilliam@odu.edu).



# OLD DOMINION UNIVERSITY

CHILDREN'S LEARNING AND RESEARCH CENTER

I D E A FUSION

## Full Day Calendar 2020-2021

### **2020**

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July 3 & 4, 2020	Closed for Independence Day Holiday
September 7, 2020	Closed for Labor Day Holiday
November 3, 2020	Closed for Election Day Holiday
November 6, 2020	Close at 1:00pm for Professional Development
November 25, 2020	Close at 12:00pm for Thanksgiving Break
November 26-27, 2020	Closed for Thanksgiving Break
<b><i>December 21, 2020 – January 1, 2021</i></b>	<b><i>Closed for Winter Break *</i></b>

### **2021**

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January 4, 2021	Center Reopens after Winter Break
January 18, 2021	Closed for Martin Luther King Day
March 11-12, 2021	Closed for Professional Development
May 31, 2021	Closed for Memorial Day
June 18, 2021	Close at 1:00pm for Professional Development
July 5, 2021	Closed for Independence Day

\* Subject to change depending on the ODU operating calendar

