OLD DOMINION UNIVERSITY

CHILDREN'S LEARNING AND RESEARCH CENTER

I D E A FUSION

Registration Form

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 address (es):		
Health Concerns/Special Needs			

☐ I do not want to be included in the CLRC directory.

Parent/Guardian Information

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

Emergency Information

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

*Appropriate paperwork shall be attached if a parent is not allowed to pick up the child.*Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in licensed child care center must be included, upon the request of such noncustodial parent, as emergency contact for events occurring during school activities.

Agreements

Initial	1. The Children's Learning and Research 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 Children's Learning and Research Center to obtain immediate medical care if an emergency occurs and I cannot be located immediately. I will not hold ODU or the Children's Learning and Research Center financially responsible for the emergency care or transportation of my child.
Initial	3. I agree to inform the Children's Learning and Research 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

Place of Birth	**Birth Date**	**Birth Certificate Number**	**Date Issued**
Other Form or Proof	**Date Documentation Viewed**	**Person Viewing Documentation**	

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

Date: **Notified by:**

Proof of child's identity and age many include a certified copy of the child's birth certificate, birth registration card, passpo of 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: _____
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 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: ____/____/_____

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 (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 <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) ☐ 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.*):**___/___/____

Student's Name:_____ Date of Birth: [__][__][__]

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 4th birthday unless received 6 doses before 4th birthday
- ☐ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ☐ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th 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 1st dose for children up to 2 years of age only
- ☐ 2 Measles – 1st dose on/after 12 months of age; 2nd 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 – 1st dose on/after 12 months of age; 2nd 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 6th Grade**

- ☐ Tdap – booster required for entry into 6th 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

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

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: _____mm

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	☐	☐	☐

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 ☐ epi pen ☐ 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):

Name . _____ Signature: _____ Date. ___/___/_____

Practice/Clinic Name: _____ Address: _____

Phone: ___-___-_____ Fax: ___-___-_____ Email: _____

MCH 213 F revised 4/07

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. _____
_____
_____

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

Half Day Program Policy Agreement

I understand and agree to the following:

1. Program hours are 9:00a.m. to 1:00 p.m. (Drop off may begin at 8:30)

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 will not apply sunscreen, bug spray, chapstick 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 State Health Department. Life threatening diseases will be reported immediately.

8. Monthly tuition payments are due by the 1st of each month if not paid at the beginning of the semester. On the 10th 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 Child Development Parent Handbook and agree with the policies contained in it.

Child's Name_____

Parent's Signature_____ Date_____

Revised 8/25/14

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

ODU CLRC Half Day Preschool Tuition Agreement Form

Child's Name_____ Date of Birth_____

Parent(s) Name_____

Parent(s) Name_____

Tuition Rate	**Full Time Faculty/Staff Full Time Students**	**Community Members**
Required Annual Materials Fee (Due with registration)	$100	$100
Monthly Payment- due 1st day of the month (September- May)	$340	$355

I will pay: _____ monthly (9 months)

I certify I am: _____ODU Full-time Faculty or Staff UIN _____

_____ Current Full-time ODU Student UIN_____

_____Community At-Large

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 day 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
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

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 _____

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

USDA Participation Form

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** _____

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

1 All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	Check if NO income	Ages of children at center	FOSTER CHILD Skip to Part 6 if all are foster children.	SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. MUST BE SEVEN (7) DIGITS
1.	☐		☐	
2.	☐		☐	
3.	☐		☐	
4.	☐		☐	
5.	☐		☐	
6.	☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

5 Total Household Gross Income (before deductions) You must tell us how much and how often

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IS RECEIVED (example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X – X X – ____ ____ ____ ____
Social Security Number

☐ I do not have a social security number.

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Date	*Printed Name of Adult Household Member*	*Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code)	*Home Telephone Number (Include Area Code)*	*Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (*FAMIS*)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia? If yes, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: _____ Sign here: _____

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of your social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

CHILD CARE REPRESENTATIVE USE ONLY - ELIGIBILITY DETERMINATION - COMPLETE SECTIONS I and II ONLY

SECTION I Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

Convert income only if different frequencies of pay are reported.

TOTAL INCOME $_____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year

NUMBER IN HOUSEHOLD: _____

☐ FREE based on:	☐ REDUCED based on:	☐ DENIED reason:
☐ foster child ☐ migrant ☐ SNAP or TANF ☐ homeless ☐ runaway ☐ household income	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/TANF

SECTION II Signature of Determining Official: _____ Date: _____

Annual Enrollment Form

Virginia Child and Adult Care Food Program

ONE FORM PER ENROLLED CHILD, NEW FORM MUST BE COMPLETED EVERY 12 MONTHS

This form is required for:	This form is NOT required for:
Child Care Centers, Head Start, Even Start, and Licensed Outside School Hours Programs	At-Risk After-School, or Emergency Shelters

Center Information – *Sponsoring institutions should pre-fill this section*

Center Name			CACFP Sponsor Number
Old Dominion University Children's Learning & Research Centers			59101
Center Address	**City**	**State**	**Zip Code**
4501 Hampton Blvd. Suite 139 (Center 2)	Norfolk	VA	23529
1520 W. 48th Street (Center 1)	Norfolk	VA	23529

PARENTS/CENTERS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete and review a CACFP Annua Enrollment Form when enrolling their child(ren) and 12 months thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or guardian must complete Sections 1 through 6. The parent must review to ensure accuracy; ther complete Section 5, sign and date Section 6.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK							MEALS RECEIVE
		TIME IN (check AM/PM and record time)			TIME OUT (check AM/PM and record time)			TIME CHILD ATTENDS SCHOOL (record in/out times)	
		AM	PM	Time	AM	PM	Time	Leaves Center	Returns To Center	
Child's First Name	☐ Monday									☐ Breakfas
Child's Last Name	☐ Tuesday									☐ AM Snac
	☐ Wednesday									☐ Lunch
Date of Birth *Age*	☐ Thursday									☐ PM Snac
	☐ Friday									☐ Supper
	☐ Saturday									
	☐ Sunday									
	☐ Yes ☐ No	I work multiple shifts and child(ren) may be in care different days/hours.								

5 Ethnic/Racial Categories

Please answer both questions. This information is voluntary.

A. Ethnic data of child(ren): Mark one only	☐ Hispanic or Latino	☐ Not Hispanic or Latino			
B. Racial data of child(ren): Mark all that apply	☐ Asian	☐ White	☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander	☐ American Indian o Alaska Native

6 Signature and Date (parent or guardian must complete this section)

I certify the information above is correct.

Signature of Parent or Guardian | *Date* | *Parent's Telephone Number*

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in th form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

Child Care Representative Use Only

Effective Date of This Enrollment Form: _____

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This form is effective for 12 months from the date of parent signature.

Signature of Center Representative | *Date*

OLD DOMINION UNIVERSITY

CHILDREN'S LEARNING AND RESEARCH CENTER

IDEA FUSION

Sick Child Policy Form

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 Children's Learning and Research Center Sick Child Policy and agree to the terms outlined.

_____

Child's Name

_____ _____

Parent's Signature Date

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

Getting To Know Me Form

Child's Name_____ Birthday_____
Name likes to be called_____
Primary language spoken in the home_____
Time I will usually be picked up_____ and dropped off_____

Emergency contacts (in order they should be called):

Name	Relation to Child	Cell#	Work#	Home #

Family:

My family consists of:
_____ relationship_____
_____ relationship_____
_____ relationship_____
_____ relationship_____
_____ relationship_____
_____ relationship_____
_____ relationship_____
_____ relationship_____

Other people important to me are:

_____

_____

Pets:

_____

Routines: (Please check the answer that best describes)

I take a nap _____daily, _____sometimes, _____rarely.
I go to bed at: _____
I wake up at: _____
I sleep well at night. _____ I wake up often at night._____

I usually eat dinner at: _____
I like to eat the same foods. _____
I like to eat a variety of foods._____

I mostly dress by myself._____
I try to dress myself but need lots of help. _____

Likes and Dislikes:

I love to _____.

I don't like to _____.

My favorite activities are:

_____

_____.

I get frustrated when I try to: _____.

My favorite toy: _____

I have books read to me _____very often _____sometimes _____ not very often.

I love to have books read to me. _____.
I like to have books read to me sometimes_____.
I don't enjoy having books read to me _____.

I watch TV/ movies about _____ minutes daily.

I like_____ don't like _____ to sing and dance to music.

When I play, I like to play
alone_____ with one person_____ with many people_____.

I feel somewhat comfortable in new situations_____.
I am very uncomfortable in new situations_____.

Information You Would Like Us to Know:

What makes your child special? _____

_____

Do you have any special concerns you'd like us to be aware of?

_____

_____

What are your goals for your child this year?

_____

_____

_____

Form Completed by: _____
Relationship: _____

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
I D E A FUSION

Nut Free Zone Policy

IMPORTANT!

The Children's Learning and Research 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 683-3081or by e-mail at jglasgow@odu.edu.