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

# 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 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) 1. | Address | Phone |
|---|---|---|
| 2. | Address | Phone |
| Person(s) Authorized to Pick Up Child | | |
| Person(s) **NOT** 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_____

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**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, passport 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.

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# 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:_____/_____/__ MCH 213

F revised 4/07

**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: *Last* *First* *Middle* Date of Birth: |____|____|____| *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.*):** __/__/__

## *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

**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

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:** _____

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
IDEA 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

# ODU CLRC Full Day Program Tuition Agreement

Please fill out one form per child.

Child's Name_____ Date of Birth_____

Parent(s) Name_____ S.S.N._____

Parent(s) Name_____ S.S.N._____

| **Effective 8/1/2017** | Weekly (paid 52 weeks) | | Monthly (paid 12 months) | |
|---|---|---|---|---|
| CLRC is open 49 weeks per year | ODU Full-Time Faculty/Staff and Current Students | Community Members | ODU Full-Time Faculty/Staff and Current Students | Community Members |
| 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 |

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

# CLRC Full Day Policy Agreement

I understand and agree to the following (initial each item):

_____ 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$^{th}$ of each month. 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 Children's Learning and Research Center Parent Handbook and agree with the policies contained in it.

Child's Name_____

Parent's Signature_____ Date_____

Revised 6/5/2017

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 _____

# Virginia CACFP Annual CACFP Enrollment Form (Child)

## CENTER/PROVIDER COMPLETE THIS SECTION

_____

*Center/Provider Name*

_____ _____ **VA** _____

*Street Address* *City* *State* *Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate annual Enrollment Form per child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5 below**.

| **This form is required for:** | **This form is NOT required for:** |
|---|---|
| Child Care Centers, Family Day Care Homes, Licensed Outside School Hours Care Centers | At-Risk Afterschool Centers, Emergency Shelters |

| 1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | 2 DAYS OF WEEK IN ATTENDANCE | 3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK | | | 4 MEALS RECEIVED |
|---|---|---|---|---|---|
| | | TIME IN | TIME OUT | SPORADIC SCHEDULE (no set schedule of days) | |
| _____ *Child's First Name* | ☐ Monday | | | | ☐ Breakfast |
| _____ *Child's Last Name* | ☐ Tuesday | | | | ☐ AM Snack |
| _____ *Date of Birth (m/d/yy)* | ☐ Wednesday | | | | ☐ Lunch |
| _____ *Age* | ☐ Thursday | | | | ☐ PM Snack |
| | ☐ Friday | **NOTES:** | | | ☐Supper |
| | ☐Saturday | | | | ☐ EV Snack |
| | ☐ Sunday | | | | |

**5 Parent/Guardian Signature and Date:**

***By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Enrollment Form and that the information contained on this form is true and correct.***

_____ _____

*Printed Name* *Signature*

_____ _____

*Street Address* *City, State, Zip Code*

_____ _____

*Phone Number WORK/CELL (circle one)* *Date*

**RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | American Indian or Alaska Native | ☐ | Asian | ☐ | Black or African American |
| ☐ | Native Hawaiian or Other Pacific Islander | ☐ | White | ☐ | Other |

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**NON-DISCRIMINATION STATEMENT:** In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1) mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;
2) fax: (202) 690-7442; or
3) email: program.intake@usda.gov.

This institution is an equal opportunity provider

## *Child Care Representative Use Only*

Effective Date of This Enrollment Form: _____
*(m/d/yy)*

Effective Withdrawal Date of This Enrollment Form: _____
*(m/d/yy)*

_____
*Printed Name of Center Representative*

_____
*Signature of Center Representative*

***The effective date may be retroactive 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.

*Revised July 2017; Previous Versions Obsolete*

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

## 1 All Household Members | 2 | 3

| NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] | | | | FOSTER CHILD | SNAP, TANF or FDPIR CASE # |
|---|---|---|---|---|---|
| | First, Middle Initial, Last | Check if **NO** income | Ages of children in care | Skip to Part 6 if all are foster children. | Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. **SNAP and TANF MUST BE NINE (9) 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 IT 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. | |
| | **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: _____

## *CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW*

**SECTION A**

**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 S_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

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

**SECTION B** **Signature of Determining Official:** _____ **Date:** _____

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

# 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.

_____
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 _____

OLD DOMINION UNIVERSITY
CHILDREN'S LEARNING AND RESEARCH CENTER
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# Getting To Know Me

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

Time I go to bed _____
Time I wake up _____
I sleep well at night _____
I wake up often at night _____

Time I usually eat dinner _____
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 like to:

I don't like to:

My favorite activities are:

I get frustrated when:

My favorite toy is:

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: _____