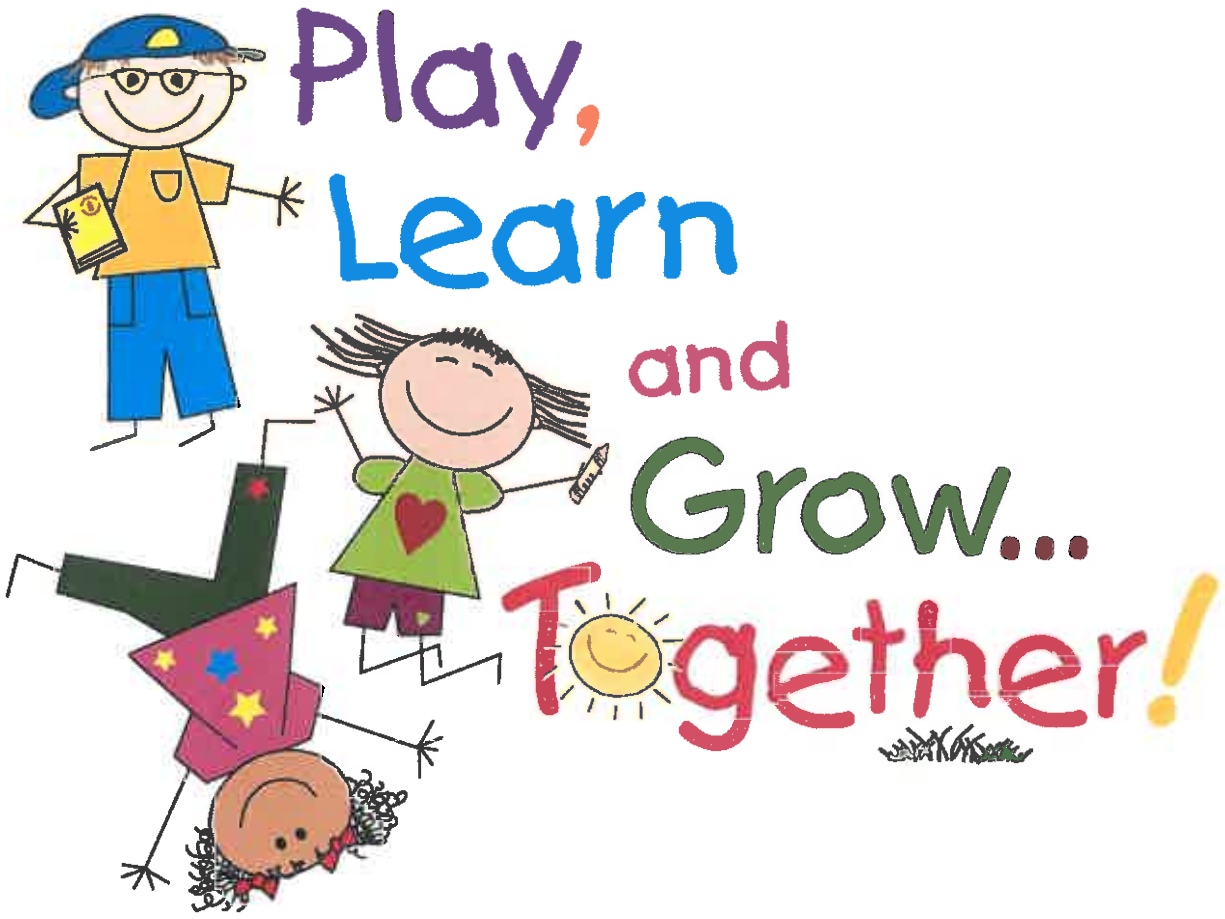
Meredith Loughran Preschool
Sandston Presbyterian Church



Registration Packet
2024-2025

Meredith Loughran Preschool
Sandston Presbyterian Church
13 N. Confederate Avenue
Sandston, VA 23150
(804)737-1527

Dear Parent/Guardians,

Thank you for enrolling your child/children at Meredith Loughran Preschool at Sandston Presbyterian Church! The first day of school is an exciting milestone in your child's life. Your child is embarking on a journey that will lead them on many roads of discovery and learning. As wonderful as this new experience may be, it can also be quite stressful for the young child. New situations and change can, at times, be unsettling for all of us. For many children this may be their first experience of separation from parents or care givers at home. It is common for even the most outgoing child to be anxious the first day of school.

We have a one-time registration fee of $50.00 per child that is non-refundable. Other Enrollment Fees are listed on a separate sheet.

We have provided a few suggestions for assisting your child during this time. Remember the preschool staff will be available to provide support and assistance, making your child's first school days happy days.

- Prepare your child for the new school experience by explaining what to expect. Answer all questions directly and honestly.
- Convey a positive attitude. Young children are aware of your feelings. Your enthusiasm will assure your child that school can be a fun and exciting place.
- Establish a routine involving both the night before a school day as well as morning preparation. Rituals and routines will add predictability and are comforting in unfamiliar situations.
- Bring something from home. This is acceptable and often reassuring in helping your child with the initial adjustment to school. This item may be a treasured blankie or even a photo from home.
- Clearly state to your child where you will be and when you will return. It may also be helpful to discuss what will happen when you are reunited.
- Maintain a clear good-bye routine. This may include warning your child you are leaving in 3 minutes, a kiss and hug, or a wave from the window. Once you tell your child you are leaving it is important to follow through. Extending the good-bye with, "Ok just one more kiss, and then I really have to go" tends to heighten anxiety rather than relieve it. Avoid sneaking out, as this seems to encourage children to become less trusting and makes the second day of school even harder.

Again, please know we are here to help make the first day of school a happy transition and we look forward to an exciting and fun year. Welcome!

Sincerely,
Devon Pence, Director

Registration Checklist

- $50 Registration Fee & Weekly Program Rate (per child)
- Parent/Guardian Information Form
- Emergency Contacts & Authorized Pickup Forms
- Commonwealth of Virginia School Entrance Health Form with current Immunization Records (Parts 1,2 & 3)
- Photo Release Form
- Volunteer Form
- Allergy Form
- Over-the-Counter Medication Form
- Prescription Medication Permission Form
- Copy of Parents Driver's License or ID
- Copy of Birth Certificate (original must be shown to staff on or before parent orientation meeting)
- Enrollment Contract (parent/director orientation meeting)

Meredith Loughran Preschool at Sandston Presbyterian Church

Registration

Please attach cash, check, or money order for $50.00 non-refundable registration fee.

Registration Date: _____ **Registration $50 Fee:** Cash ___ Check ___ Money Order ___

Child Information

Last Name	First Name	MI	Nickname

Entering Grade	Gender __Male __Female __Prefer not to Specify	Date of Birth	Birth City/State	Social Security #

Existing medical conditions, medications, allergies and/or special attention your child may require.

1. _____
2. _____
3. _____
4. _____
5. _____

Indicate Which Program

Programs (8:00am to 5:00pm)	**Cost**
____ 5 Day Program (Monday through Friday)	$140.00 per week
____ 3 Day Program (M – F any 3 days)	$120.00 per week

Parent Signature:_____ Date:_____

Primary Guardian Information

Name(s) of person(s) with whom child is living

1st Primary Guardian

Last Name	First Name	M.I.	Relationship to Child

Email Address	Work Phone	Cell Phone

Occupation	Employer	Work Address	Work Hours

2nd Primary Guardian

Last Name	First Name	M.I.	Relationship to Child

Email Address	Work Phone	Cell Phone

Occupation	Employer	Work Address	Work Hours

Which Guardian Should be Called First?	Home Phone	Preferred language for written communication:

Home Resident Street Address	Apt #	City	Zip Code

Mailing Address (if different than above)	Apt #	City	Zip Code

Second Guardian Information

Non-primary custodial parent

1st Non-primary Guardian

Last Name	First Name	M.I.	Relationship to Child

Email Address	Work Phone	Cell Phone

2nd Non-primary Guardian

Last Name	First Name	M.I.	Relationship to Child

Email Address	Work Phone	Cell Phone

Which Guardian Should be Called First?	Home Phone	Should mailings be sent to this household also? [ ] Yes [ ] No

Second Household Mailing Address	Apt #	City	State	Zip Code

Additional Comments & Information:

Emergency Contacts and Authorized Pickups

1st Contact/Pickup

Last Name	First Name	Relationship to Child

Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children:

2nd Contact/Pickup

Last Name	First Name	Relationship to Child

Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children:

3rd Contact/Pickup

Last Name	First Name	Relationship to Child

Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children:

Additional Comments and Information

Is there any other information that would be helpful to our management and teaching staff?

Signature

Parent / Guardian Signature

Date

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

Name of Parent or Legal Guardian 2: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

Emergency Contact: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): _____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. ***This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.***

Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____

Signature of person completing this form: _____ Date: _____/_____/_____

Signature of Interpreter: _____ Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: |__|__|__|__|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

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

Student's Name:_____ Date of Birth: |___|___|___|___|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

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

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

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

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)). **(Requirements are subject to change.)**

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

Weight: _____lbs. Height: _____ft. _____in.

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ **No risk for TB infection identified** ☐ **No symptoms compatible with active TB disease**
☐ **Risk for TB infection or symptoms identified**
Test for TB Infection: TST IGRA Date:_____ **TST Reading** ____**mm** **TST/IGRA Result:** ☐ **Positive** ☐ **Negative**
CXR required if positive test for TB infection or TB symptoms. **CXR Date:** _____ ☐ **Normal** ☐ **Abnormal**

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead: _____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

Stereopsis	☐ Pass	☐ Fail		☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test – needs rescreen**

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___ **Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ **Date:** ____/____/_____

Practice/Clinic Name: _____ **Address:** _____

Phone: _____-_____-_____ **Fax:** _____-_____-_____ **Email:** _____

Meredith Loughran Preschool at Sandston Presbyterian Church

PHOTO RELEASE FORM FOR MINORS

By signing this form, I voluntarily grant Meredith Loughran Preschool at Sandston Presbyterian Church PC (USA) permission to photograph and/or video my child and

1. store their name and image, by means of digital or film photography, audio or video recording.
2. use their image in printed publications
3. use their image or recording in electronic publications
4. use their image or recording in web content such as a website or Facebook page created for or by the preschool for its sole Benefit

I warrant that I am the legal guardian of the child listed and that I have the legal authority to sign this agreement on behalf of the child. I can revoke permission at any time, with dated, written notice. If a dispute or any claim of damages arises over this agreement, I agree to resolve the matter through a mutually acceptable alternative resolution process. If mutual agreement cannot be reached, the dispute **Will** be submitted to a three-member arbitration panel of the American Arbitration Association for final resolution.

Meredith Loughran Preschool at Sandston Presbyterian Church will never publish a child's name with any of its publications.

Child's Full Name:_____

Parent or Guardian's Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Parent or Guardian's
Signature:_____Date:_____

Revised 2/1/2021

Meredith Loughran Preschool
Parent Volunteers

If you are interested in volunteering, we would love to have your help! Please fill out this volunteer form with the days and times that you are available and how you would like to volunteer.

Volunteer Name: _____
Phone Number: _____
Email Address: _____
Students Name: _____

Please circle the days you would like to volunteer.

Monday Tuesday Wednesday Thursday Friday

Please indicate the times you are available.

_____

I am interested in the following volunteer opportunities:
(Please check any that apply)

___Reading to the Class
___Special Events/Parties
___Stand in/Substitute (will require a background check)
___Other_____

THANK YOU FOR VOLUNTEERING!

Meredith Loughran Preschool at
Sandston Presbyterian Church
Allergy Form

Child's Name: _____ Date of Birth: _____

Please list any of your child's allergies and any medical conditions that your child may have.

Allergies: _____

Type of Reaction: _____

*Medication: _____

*Instructions for Use: _____

(* This gives us permission to administer allergy medications as instructed.)
(** All medications MUST be provided by Parent/Guardian in original packaging)

If my child has an allergy, I authorize that my child's name may be posted in the classroom as a reminder to staff to prevent allergic reactions. This is especially important to keep your child as safe as possible and involved in a healthy environment.

Physician's Signature _____ Date: _____

Parent's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Meredith Loughran Preschool

Over-the-Counter Medication Form

Name _____

Date _____

I give permission for, _____ to use the following over-the-counter or external preparations as needed according to the directions for use on the container. Note: If the directions for use are not specific on the container, (such as Tylenol for a child under the age of 2), I will need a physician's note with the appropriate dosage.

*Denotes items that must be supplied by parents. All must be in the original container clearly labled with the child's name.

* ( ) Acetaminophen

* ( ) Ibuprofen

* ( ) Benedryl

* ( ) Baby Wipes

* ( ) Baby Lotion

* ( ) Baby Powder

* ( ) Sunscreen

* ( ) Insect Repellent

( ) Band-Aids

( ) Neosporin or similar Ointment

( ) Bactine or similar First Aid Spray

Parent Signature _____

Parent Signature _____

This consent is valid for 1 (one) year.

Meredith Loughran Preschool

PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION

Child's Full Name _____

Date _____

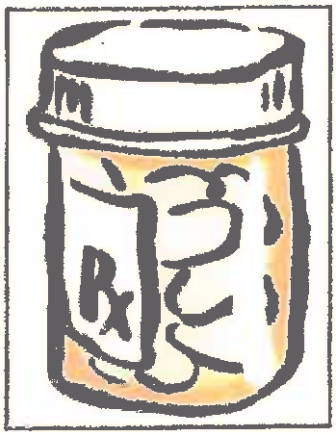
Name of medication _____

Dosage _____

Time(s) of Dosage _____

Any special instructions (take with food, on an "as needed" basis, etc.):

_____



Start Date of Prescription _____

End Date of Prescription _____

Possible side effects _____

_____

Rx Number _____

Name of Pharmacy _____

Pharmacy Address _____

Pharmacy Phone _____

Name/Phone of prescribing Physician _____

I release _____ **from any liability from administering**
(name of provider)

this medication.

_____ _____
(parent signature) (date)

***All Prescription Medication must be in the original container clearly labeled with the child's name and dispensing instructions.**