Mother's Day Out Preschool
Alexandria, VA. 22312

REGISTRATION CHECK LIST

Name of Student:_____

Mother's Name:_____ Phone:_____

Father's Name:_____ Phone:_____

Days in School Mon Tue Wed Thur Fri Fee for Month

Registration/Application Form: _____

Student Information Form: _____

Emergency and Information Form: _____

Permission to Pick/Drop Form: _____

Virginia State Entrance & Health Form: _____

Parent/Guardian Financial Agreement: _____

Fees and Tuition Form: _____

Copy of Birth Certificate: _____

Religious Exempt Form: _____

Consent to Publish: _____

Code of Behavior: _____

Current Photo: _____

OFFICE STAFF ONLY:

Registration Fee Paid:

Check:_____ Money Order:_____

Date:_____

Notes:

Mother's Day Out Preschool
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APPLICATION FORM

Child's Information

Child's Name:_____ Gender:_____ Date of Birth:_____

Home Address:_____

Home Phone:_____

Basic Information

Mother/Guardian's Name: _____

Home Phone:_____ Cell Phone: _____

Email Address: _____

Address: _____

Employer:_____ Work Phone:_____

Father/Guardian's Name

Home Phone:_____ Cell Phone: _____

Email Address: _____

Address: _____

Employer:_____ Work Phone:_____

Party of Parties Responsible for Payments

Name: _____ Home Phone: _____

Home Address:_____ Cell Phone: _____

Relationship to Student:_____ Email: _____

Nondiscrimination policy

Mother's Day Out Preschool admit students of any race, color, national origin, and ethnic origin to all the rights, privileges, programs and activities generally afforded or made available to students at the school. It does not discriminate on the basis of race, color, national origin, and ethnic origin in administration of its educational policies and admission policies.

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STUDENT INFORMATION SHEET

Child's Name: _____ Date of Birth: _____

Has your child been in a preschool environment? ____ If yes how long?_____

List most recent ones: _____

Sibling's name and ages:_____

List any allergies your child has including milk, fruit juices, nuts, etc.

List any special needs (does not speak English, learning disabilities, etc.) you would like us to know

How do you discipline your child?

Favorite play activities:

Favorite toy:

Favorite book and stories:

Is your family affiliated with a church?

Does your child attend Sunday school?

Does your child attend Vacation Bible School during the summer?

If you are not affiliated with a church, would you consider Braddock your home church?

Please share other information about your child that will help us to make preschool a happy experience:

How did you hear about Mother's Day Out Preschool?

What is your child's t-shirt size?

2-4, (x-small) 6 - 8 (small) 10 - 12 (medium) 14-16 (large)

(These shirts tend to run small so I would suggest ordering a size larger than normal wear).

"I have read the Mother's Day Out Preschool handbook; I understand and comply with all policies, tuition cost and fees."

Parent's Signature:_____ Date: _____

Date received in Preschool Office:_____ (Registration Fee Included)

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EMERGENCY INFORMATION FORM

Child's Name:_____ Date of Birth:_____

Address:_____

Father's Name:_____ Cell/Work Phone:_____

Mother's Name:_____ Cell/Work Phone:_____

List any significant medical history for your child that we would need to know to inform emergency personnel in the event we cannot contact a parent:

Does your family have any religious beliefs that would impact emergency medical care?

Do you have medical insurance? If yes, name of insurance: _____

Policy Holder's Name: _____

Group Number: _____ Policy Number:_____

Physician's Name:_____ Phone:_____

Physician's Address: _____

Person to be called in case of emergency if parent cannot be reached:

Name: _____ Phone Number: _____

Address: _____

Mother's Day Out Preschool has my permission to call my child's physician in case of emergency when parents and other emergency contact CANNOT be reached.

In the event none of the above persons can be reached, or the nature of the injury warrants, your child will be taken to:

Fairfax Hospital
3300 Gallows Road
Falls Church, VA
Phone: (703) 698-1110

or

Alexandria Hospital
4320 Seminary Road
Alexandria, VA
Phone: (703) 504-3000

I give **MDO** Preschool staff permission to provide medical aid to my child in case of emergency.

Parent/Guardian will be responsible for payment of medical care expenses.

Signature of Parent/Guardian: _____ Date: _____

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PERMISSION TO PICK/DROP

Child's Full Name: _____

Name: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Address: _____

Relationship: _____

Name: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Address: _____

Relationship: _____

Please provide a list of individuals unauthorized to pick up your child under any circumstances: _____

_____

Parent /Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Mother's Day Out request that the individual provides a photo ID before release of the child to the individual.

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: _____/_____/_____

MCH 213G reviewed 03/2014

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: _____

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FINANCIAL AGREEMENT

I wish to enroll _____ at Mother's Day Out Preschool for the period of _____

Please read carefully and initial the following statements:

1. I/we agree to pay_____ (dollars) on the first day of each month for every month my/our child is enrolled in Mother 's Day Out Preschool.
2. All fees and tuition are due on the 1st of each month. A $40 fee will be added to any tuition not paid by the 5th of each month. We will also charge a $75 fee for any returned check. If more than one returned check is received, all payments thereafter must be made by money order. Tuition not paid by the 10th will result in child dismissal until tuition has been paid.
   a. Registration fees are due at the time of enrollment. All registration fees are non- refundable.
   b. Registration fees include use of rest mat, insurance and processing fees, t-shirt, art & craft supplies.
   c. A new registration fee is required each academic year the child is enrolled.
3. There is a 1$ per minute charge for every child who is picked up 5 minutes after the school closing or the contracted hours.
4. A one-month notice must be given for the withdrawal of your child. If one month is not given tuition payment will be required.
5. Parents will be responsible for any collection costs incurred to collect monies owed.
6. The school reserves the right to dismiss any child for whom the board decide cannot fit into the program. When possible, the school will give a one-week notice.

I/we have read the above and agree to all terms.

X _____ X _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

X _____

Office Staff Signature Date

FEES AND TUITION

Registration Fee: $160.00 (non-refundable)

- Due at the time of registration
- Holds your child's place for the comingyear
- Pays for a t-shirt and use of a rest mat
- Class material

Monthly Tuition Rates (per child):

- No child is enrolled until registration fee is paid.
- All required paperwork must be on file before the child can attend.
- Due to a law enacted in 1998 ALL students MUST HAVE on file, a copy of a birth certificate. This certificate is to accompany a form included in the registration package. This MUST BE turned in by August 15th. NO EXCEPTIONS!
- New students registering later in the year must have health records and birth certificate on file **prior to** the first day of attendance.
- Payment is due on a monthly basis, on or before the 1st of the month. Standard late fees may apply.
- Make checks payable to Mother's Day Out (MDO).
- Tuition NOT refunded due to sickness, vacation, holidays, school cancellations, or withdrawal from the program early in a month. If tuition is not received within 5 days of due date (1st of the month) and no explanation is given, it may be considered a withdrawal.

Child's Name: Age:

Program Days (Monday through Friday)

Mother's Day Out Preschool
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Religiously Exempt Child Care Programs

IDENTITY VERIFICATION

Full Name of Child:

Place of Birth	Birth Date	Birth Certificate Number and its Copy	Date Issued
Other Form of Proof			

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency, record from a public school in Virginia, or certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia and the center assumes center transfers responsibility of the child directly to the school (i.e. before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Previous Day Care:

Name of Day Care Facility or Day Care Home Provider:	Address of Previous Day Care:	Dates in Care:

Date Identity Received Name of Staff Person (please print) Title of Position of Staff Person

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RELEASE CONSENT TO PUBLISH

The undersigned party, being the guardian of _____ who is currently enrolled as a student at Mother's Day Out Preschool, having been advised by the Director, of the business, that certain promotional photographs have been taken which will ultimately result in publication, does agree and consent that the photographs of the children shall be released at the discretion of the Director of Mother's Day Out Preschool.

Yes _____ No _____

Parents Signature/Guardian:_____ Date:_____

Mother's Day Out Preschool
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CODE OF BEHAVIOR

Discipline is an important part of your student's school experience. Supporting discipline and good manners requires a joint effort. Our staff will support and encourage good behavior at school and reward your student's effort.

Each child will be expected to behave in a proper manner at school as well as on field trips. If a child misbehaves in the classroom, that child would be sent to the office and a note to the parent would be sent home that day. If this behavior continues, the parent will be called and asked to pick up their child.

Proverbs 10:17 tells us "he who heeds discipline shows the way of life, but whoever ignores correctio n leads others astray."

Children cannot become self-disciplined unless adults teach them right from wrong. At Mother's Day Out, child ren will be taught the expectations for correct behavior and encouraged to live and act accordingly.

Disruptive Behavior which distracts from the full benefit of the preschool program will result in negative consequences. The following behaviors are considered disruptive:

Requires constant attention from staff
Inflicts physical or emotional harm on other childre n, adults or self
Disrespects people and materials provided in the program
Disobeys the rules established to enable a community of learners
Verbally threatens other students and/or staff
Uses verbal or physical activity that diverts attention away from the group of children

A very important part of the preschool experience is helping children learn how to get along in the world and enjoy being with other children as well as following the direction of an adult other than their parent. The teachers will focus on the positive behaviors of the children and reinforce those behaviors as often as possible.

Please read the above policy. Discuss it with your child. Love and discipline are the best gifts you can give your child.

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*I have read and understood the above CODE OF BEHAVIOR Policy.

Student's Name: _____

Parent / Guardian Signature: _____ Date: _____

Relationship to Child: _____