Centerville Preschool Academy

Shaunna Cross, Director

Dear Parents,

It is very hard to believe that your child will be ready for K5 this September. We are proud to say that they will be more than ready!

Now is the time to really seek God for direction in enrolling your child with us for another year. What greater investment in their future than a foundation built on the Christ of Calvary. Please find attached, pricing information about our K5 Program.

Jesus said, "Let the little children come to me and do not hinder them for the Kingdom of Heaven belong to such as these." Matthew 19:14.

Sincerely,

Ms. Shaunna Cross,
Director

*Before and After care is available for those who will be attending Tallwood Elementary.

1541 Centerville Turnpike Virginia Beach, VA 23464
757-424-2501 cpa1541@azaleagardencog.org

Centerville Preschool Academy
1541 Centerville Turnpike
Virginia Beach, VA 23464
757-424-2501

Kindergarten

(Must be 5 years old by September 30)

Hours of Operation

8:30am — 2:00pm

Registration	$450.00
(non-refundable)	
If paid before July 15th	**$350.00**
Tuition (weekly)	
Class only	$145.00
Before and After Care included	$170.00

Our teacher is a degreed teacher and uses a Christian based curriculum.

*Supplies are to be provided by the parents.

*Nutritious lunch and snacks are to be provided by parent.

Centerville Preschool Academy

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Closings 2019

September 2nd	Labor Day
November 28th-29th	Thanksgiving Break
December 24th & 25th	Christmas Break

Closings 2020

January 1st	New Year's Day
May 25th	Memorial Day
July 3rd	Observance of Independence Day
September 7th	Labor Day
November 26th-27th	Thanksgiving Break
December 24th & 25th	Christmas Break

Schedule is TENTATIVE and MAY change

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Centerville Preschool Academy

Information Card

Child's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

To Parent or Guardian: To better serve your child in case of accident or sudden illness that occurs at school or at a school related activity, it is required that **all** information be completed.

Program: _____Preschool _____Kindergarten _____Before & After Care/Summer

Hours: _____Full Days _____ Half Days ____AM Care ___PM Care

Emergency Contacts		
Name	**Relationship**	**Telephone**
	Mother/Guardian	Work ( )
	Email:	Cell ( )
	Father/Guardian	Work ( )
	Email:	Cell ( )
		Work ( )
		Cell ( )
		Work ( )
		Cell ( )

Additional adult authorized to pick up your child		
1)	2)	3)
4)	5)	6)

Media Consent: _____ yes _____ no

Special Heath Conditions (Include Allergies):_____

_____

Signature of Parent/Guardian:_____ Date: _____

Centerville Preschool Academy

Kindergarten FYI

Please initial the following items:

_____ 1. Centerville Preschool is a private, religious exempt program. We are not licensed with the state, but closely monitored and abide by the regulations set by the state. We reserves the right to teach Bible stories, Bible songs, and to offer prayer.

_____ 2. Tuition is due and expected on your child's first day of service. Parent is responsible for **40 weeks tuition**. A late fee of $35.00 will be applied to payment not received by Tuesday at close of business. Service **will** be **suspended** if account goes 2 weeks delinquent and student will be unenrolled from program.

_____ 3. There is a late fee of $5.00 every 5 minutes for children not picked up by 6.00 pm. If it is 6:01pm, by our clock, you are late and a late fee will be assessed. At 6:30pm, late pick up increases to $10 every 5 minutes. This applies to students who **end their day at 2:00 pm**.

_____ 4. There is a $40.00 charge levied on all returned checks. Upon receipt of the second return check, all payments must be made by a money order or cash. A $20.00 charge on checks put through once.

_____ 5. Assigned key fob(s) must be returned upon withdrawal of child. Additional or lost key fobs may be purchased for $10.00.

_____ 6. Children MUST be kept home if any of the following conditions exist:

a. A temperature of 100°F or higher.
b. Intestinal disturbance such as diarrhea or vomiting.
c. Any undiagnosed rash or sore.
d. Discharge of eyes or ears.
e. Profuse nasal drainage.
f. If child is not capable of full participation.

_____ 7. C.P.A. chooses NOT to administer prescription and non-prescription medication, with the exception of over-the-counter topical ointments, sunscreen and topically applied insect repellant provided by the parent.

_____ 8. Parents **must** provide daily snacks and lunch. No sodas or food that requires preparation.

_____ 9. Toys brought to the center are the parent's/child's responsibility. The center will not be held liable for the damage.

_____ 10. There is **NO FREE WEEK** during the school year.

_____ 11. Regular fees are due and not refundable if the school must close due to act of God, or holiday closures. Call the Center (757-424-2501) after 6:30 am for any announcements of closure due to increment weather.

I (**give/do no give**) consent to Centerville Preschool Academy to publish or copyright any photographs or videos in which my child appears while enrolled as a student in any programs of Centerville Preschool Academy. This would include but not be limited to use of photographs/videos in school brochures, school media sites, advertising, videotapes, and other like publications.

Please sign and date below:

Signature: _____ Date: _____

Centerville Preschool Academy

Decision to Not Administer Prescription Medications

My program has made the following decision regarding the administration of medications to a child in my program: (Check one)

_____ I (or my staff) **WILL NOT** administer any medications – prescription or non-prescription medication (non-prescription medications include but are not limited to, Tylenol, cough syrup, diaper ointment, sunscreen, and topical insect repellants).

__X__ I (or my staff) will administer **ONLY** non-prescription medications (non-prescription medications include but are not limited to, Tylenol, cough syrup, diaper ointment, sunscreen, and topical insect repellants).

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name: Shaunna Cross	Facility Name: Centerville Preschool Academy
Provider's Signature:	Date:
Parent/Guardian Signature:	Date:

Confidentiality Statement

Information about any child in my program is confidential and will not be given to anyone except VDSS' designees or other persons authorized by law unless the child's parent or guardian gives written permission. Information about a child in my program will be given to the local department of social services if the child received a day care subsidy or it the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

Rehabilitation Act of 1973

I understand that if my program received any federal funding (such as child care subsidy from a local department of social services), I am subject to section 504 of the Rehabilitation Act of 1973 which is similar to the provisions of the Americans with Disabilities Act. If a child enrolled in my program now or in the future is identified as having a disability covered under the Rehabilitation Act, I will assess the ability of the program to meet the needs of the child. For further information on the Rehabilitation Act seek legal counsel and/or go to the following website: http:www.dol.gov/oasam/regs/statutes/sec504.htm

Provider Statement

I understand that it is my responsibility to follow my *Program's Decision Regarding Medication* plan and all health, infection control, and medication administration regulations applicable to my child day program. The Program Decision Regarding Medication plan will be made available to my parents at enrollment, whenever changes are made, and upon request.

Centerville Preschool Academy

Shaunna Cross, Director

Birth Certificate Requirement
(Must physically see birth certificate)

Student's Full Name _____

1. **Certified Birth Record Presented**

   Date of Birth _____/_____/_____ Sex _____

   State File Number/B.C. Number _____

   Date B.C. issued _____/_____/_____

   Date document viewed _____/_____/_____

   Signature of School Official _____

   _____
   (Title)

2. **Certified Birth Record is not Presented and Affidavit is Completed**

   Expiration date of Affidavit _____/_____/_____

   Date document viewed _____/_____/_____

   Person viewing documentation _____

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:** _____