DOCUMENTS TO RETURN TO YOUNG CHILDREN'S PROGRAM

New Students	Returning Students	
☒	☒	Registration Forms
☒	☒	Emergency Information Form
☒	☒	Child Release Authorization Form
☒	☐	VDOE Agreement Form
☒	☐	Commonwealth of VA School Entrance Health Form
☒	☐	Program Permission Forms (Support of YCP Mission, Field Trip, Display of Art, Photography)
☒	☐	Young Children's Program Policy Contract (final page of Family Handbook)
☒	☐	Birth Certificate*

If Your Child Has Special Health Care Needs:

*forms available upon request from the YCP office***

☒	☒	VDOE Written Medication Consent (if your child may require medication at school for an emergency health condition)
☒	☒	VDOE Individual Health Care Plan (if your child has a chronic health condition—including a food or environmental allergy--that requires the attention of the YCP staff)

* Licensing standards require documentation of each child's identity and age upon initial entrance to the Young Children's Program. **Parents of new students should bring their child's certified birth certificate or other official record to the preschool office.** If your child does not have a birth certificate, it is important that you send for one immediately (forms are available online and in most doctor's offices). **It will be necessary for you to bring a copy of your request form or letter to the conference as temporary verification.** If your child attended the YCP last year, you do not have to bring the birth certificate again. **We MUST have all paperwork completed, including the record of a health examination and immunizations, before your child can be allowed to attend school.**

REGISTRATION FORM

YOUNG CHILDREN'S PROGRAM
College of Education
James Madison University

Child's full name	Preferred name	Sex ☐ male ☐ female
Child's Address	Home phone	Date of birth

Adult Family Member Name	Place of employment		
Address ☐ same as child	Home phone	Business phone	Cell phone
Adult's Email address			
How can you usually be reached during school hours?			

Adult Family Member Name	Place of employment		
Address ☐ same as child	Home phone	Business phone	Cell phone
Adult's Email address			
How can you usually be reached during school hours?			

Person(s) or agency having legal custody of child (if other than adults listed above) ☐ N/A

Home address (if different than above) ☐ N/A	Home phone ☐ N/A
Business address (if different than above) ☐ N/A	Business phone ☐ N/A

Siblings (include step brothers and sisters if applicable)

	First Name	Age
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Our child's name, adults' names, home phone number, and address may be included in the class roster and YCP directory to be distributed to YCP families.
☐ yes ☐ no

Our family has internet access and is comfortable receiving program and class information via email, Seesaw, and the YCP website.
☐ yes ☐ no

INTRODUCTION TO YOUR CHILD

What are your child's interests, favorite activities and/or toys?

Does your child have specific anxieties or fears? ☐ yes ☐ no
If yes, please describe.

Describe your child's toileting routine. How frequently does he or she have accidents?

What are your child's strengths?

In what ways would you like to see your child grow this year?

What are current child care arrangements when your child is not at the YCP?

Has your child had the opportunity to play with other children his/her age? ☐ yes ☐ no
How does your child behave when interacting with other children around his/her age?

Does your child speak English? ☐ yes ☐ no

Are there languages other than English spoken in your home? ☐ yes ☐ no
If yes, what languages?

Is there information you would like to share about your child's language and how the YCP can support your family?

Do you wish to receive communication from the Young Children's Program in a language other than English?
☐ yes ☐ no
If yes, what language?

Is there information you wish to share about your family's beliefs, practices, or structure that will help us in learning to know your child and meeting his or her needs at school?

HEALTH INFORMATION

Does your child have speech, hearing, sight, or motor difficulties? ☐ yes ☐ no
If yes, please describe thoroughly and provide any information that will help the teaching staff respond to the condition appropriately.

Does your child have allergies or intolerances to food, medication, or other substances? ☐ yes ☐ no
If yes, please describe.

May information about his or her allergy and/or intolerance be posted in the classroom to facilitate staff awareness and compliance with the child's needs? ☐ yes ☐ no

VDOE licensing requires the development of an Individual Health Care Plan for this condition that must be signed by your child's physician before the opening of school. Contact the YCP Director for a copy of this form and to schedule a time to develop this plan.

Does your child have a chronic health condition or health limitations in addition to those described above? ☐ yes ☐ no
If yes, please describe.

VDOE licensing requires the development of an Individual Health Care Plan that must be signed by your child's physician before the opening of school. Contact the YCP Director for a copy of this form and to schedule a time to develop this plan.

Does your child take medication regularly? ☐ yes ☐ no
If yes, please describe.

In what ways does the medication affect your child's behavior?

Medication will be administered at the YCP for emergency medical conditions only. Does your child's medication meet this criterion? ☐ yes ☐ no

If yes, VDOE licensing requires submission of a Written Medication Consent that must be completed and signed by the physician, parent, and program every six months. Please contact the YCP Director or Program Assistant for a copy of this form so it can be completed before the opening of school.

Because of the active chemical ingredients in sunscreen and insect repellent, VDOE licensing considers them medications. The YCP strongly encourages parents to apply these topical treatments BEFORE coming to school when you feel they are needed. If there is a medical reason for why this is not acceptable, a Written Medication Consent must be completed and sunscreen or insect repellent must be provided by the parent in its original container labeled with the child's name. Contact the YCP Director or Program Assistant if you need a copy of this form.

If your child needs sunscreen or insect repellent, do you plan to administer it before sending your child to school?
☐ yes ☐ no

AGREEMENTS

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) ***Date***

_____ _____

Administrator of Center ***Date***

Date Child Entered Care: _____ Date Left Care: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

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

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

_____

Date

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 (foster care and adoption agencies), record from a public school in Virginia, 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 or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the 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.

Section 63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding,. (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means.

YOUNG CHILDREN'S PROGRAM
College of Education
James Madison University

Please complete this form with a dark pen.

EMERGENCY INFORMATION FORM

Child's name	Home phone
Child's address	

In the event of an emergency, a parent will be contacted as soon as possible. Please list all phone numbers where you may be reached.

Adult Family Member #1	Relation
Phone numbers (in priority order)	
Adult Family Member #2	Relation
Phone numbers (in priority order)	

A minimum of two additional emergency contacts must be listed. If neither parent can be located, attempts will be made to contact these individuals in the order listed.

Contact #1	Relation
Complete address	Phone number(s)
Contact #2	Relation
Complete address	Phone number(s)

Child's physician	Physician's phone number

Health insurance carrier	Policy number	Name of insured
☐ My child is not covered by a health insurance policy.		

☐ Members of the YCP teaching staff may have access to the health insurance information I have submitted.
☐ I am not willing to disclose information regarding my child's health insurance coverage.

I authorize the staff of the Young Children's Program to obtain immediate medical care if an emergency occurs and a parent cannot be located immediately.

Date	Printed name of Adult Family Member	Signature

CHILD RELEASE AUTHORIZATION

Child's name	Parents
Full name individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)
Full name of individual	Phone number (s)

I (we) hereby authorize the staff of the Young Children's Program to release my (our) child to any of the individuals listed above. I (we) understand that this list may be updated at any time and that children will be released only to persons I (we) have authorized.

*The following person(s) is NOT authorized to pick up my (our) child. _____

_____	_____	_____
Date	Printed name of Adult Family Member	Signature

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

YOUNG CHILDREN'S PROGRAM
College of Education
James Madison University

PROGRAM PERMISSION FORM

Teacher's name: _____

Child's full name: _____

Support of the YCP Mission as a Laboratory School

The Young Children's Program is a laboratory school operated by the James Madison University College of Education. As such, its mission includes presentation of an exemplary program for young children, as well as educational services to teacher education students and faculty. It is expected that parents who choose to send their child to a laboratory school understand and support the vital role it serves in the development of education professionals.

Respect for the privacy of YCP children and families is required of all adults who participate in the program. Child records are stored in a locked cabinet that is accessible only to staff and regulatory officials. Work sample portfolios are stored in the YCP office where they are accessible only to staff and parents. Student and faculty projects include written records of children's language and behavior, program research, and collection of work samples. Names of individuals are NEVER used by students or faculty in projects, publications, or research.

Teachers frequently take pictures of class activities for use in charts, family newsletters, teacher-made books, and the classroom calendar. Student staff members take photos for use in assignments that require visual documentation of their understanding of course content. Faculty photography is used in university classes and professional presentations. Children are NEVER identified by name in faculty/student photos or video recorded at the YCP for professional use. Pictures for submission to professional journals must be approved individually by the child's parent.

I understand the above practices of the Young Children's Program as a laboratory school and grant permission for my child's full participation.

_____	_____	_____
Date	Printed name of parent or guardian	Signature

Field Trip Permission

My child,_____, has permission to participate in walking and vehicular field trips sponsored by the JMU Young Children's Program during the school year. I understand that I will be notified in advance of trips involving vehicle transportation, that adequate adult supervision will be assured at all times, and that the YCP *Field Trip Policies and Procedures* will be followed.

I have read the *YCP Field Trip Policies and Procedures* and understand my responsibilities when serving as a field trip chaperone.

_____	_____	_____
Date	Printed name of parent or guardian	Signature

Permission for Display of Children's Art

Opportunities for self-expression are available daily at the YCP because of their importance in supporting all areas of development and learning. Art created by children in the program is featured on the YCP website anonymously. Occasionally YCP student art is solicited for exhibitions on campus and at professional conferences. Children's names are usually displayed with their art in exhibition settings.

I understand the above practices of the Young Children's Program and grant permission for display of my child's art.

Date	Printed name of parent or guardian	Signature

☐ I prefer that my child's name not be included in art displayed in exhibitions.

Permission for Use of Photography on the College of Education and YCP Web Sites and Social Media

The College of Education (including the YCP) web site provides thorough descriptions of all its programs and is used as a tool for communicating with families, students, the University community, and the public. An attempt is made to keep information and images as current as possible. With parental permission, pictures of children involved in activities sponsored by the Young Children's Program are used without personal identification.

I understand the above use of pictures taken at the Young Children's Program. Pictures of my child may be included on the College of Education and YCP web sites and Social Media sites without use of his or her name.

Date	Printed name of parent or guardian	Signature

☐ I prefer to view pictures individually before granting permission for web publication.

YOUNG CHILDREN'S PROGRAM

POLICY CONTRACT

I have read ***THE FAMILY HANDBOOK*** and have had the opportunity to ask questions regarding the stated policies of the James Madison University Young Children's Program.

I agree to abide by these policies while my child is enrolled in the YCP.

_____

Signature of adult family member

_____

Date

_____

Child's full name (please print)

This document must be signed and returned to the YCP office.

YCP Before/After School Contract

The purpose of the YCP Before and After School Program is to provide quality care for students attending the YCP preschool program (3- and 4-year-olds) who may need additional care outside of the regular school day.
Families are required to pack their child's breakfast for before care if their child will eat at school as well as an afternoon snack for those staying for after school care. Supervision will consist mainly of our JMU Student staff with a ratio not to exceed 10:1.
After school ends at 5:30 pm each day. Families will be charged a $10 late fee for every 5 minutes until they are picked up. At 5:30 pm, afterschool staff will begin calling listed emergency contacts. If no one can be reached Child Protective Services and/or the Harrisonburg Police Department will be notified.

Please indicate your need for before or after school care below:

☐ **My child will attend before school care Monday-Friday. I will pay an additional $60 per month for this service.**

☐ **My child will attend after school care during the days circled below. I will pay an additional fee of $_____ as indicated by the after-school fee chart.**

Monday Tuesday Wednesday Thursday Friday

Child's Name:_____

Parent's Name: _____

Parent's Signature: _____

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 earlier 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 Code _____

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: ___-___-____

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

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)			

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 Interpreter: _____ Date ____/____/_____

COMMONWEALTH OF VIRGINIA

SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

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.*):** 12 / /

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

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				

Tuberculosis Screening

Check the box that applies:

☐ 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: ☐ Negative ☐ Positive

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.

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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:** _____