Checklist

__ Childs Record

__Information for Parents (signed by parent)

__Policy for Administration of Medications (signed by parent)

__Liability Insurance Declaration (signed by parent)

__Immunization and Physical Record Form (signed by physician, physician's designee or health official)

---

__General Permission for Regularly Scheduled Trips (signed by parent)

__Special Field Trip Permission (signed by parent)

__Medication Consent (signed by parent) ****valid for 10 days unless signed by physician**

__Permission to Participate in Swimming or Wading Activities (signed by parent)***Valid for one year**

__Injury Record(s)

# CHILD'S RECORD



- o **INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.**
- o **THE COMPLETED FORM MUST BE KEPT IN THE CHILD'S RECORD AND THE FIRST PAGE UPDATED ANNUALLY.**
- o **THE INFORMATION IN THIS FORM IS REQUIRED BY FAMILY DAY HOME STANDARD 22 VAC 40-111-60.**

| Child's Full Name | Nickname | Sex | Birth date |
|---|---|---|---|
| Street Address City State Zip | | | First Day of Attendance |
| | | | Last Day of Attendance |
| If Child Attends School, Give Name of School | | | Grade |

## EMERGENCY INFORMATION

| |
|---|
| Allergies and intolerance to food, medications, or other substances. Actions to take in emergency situation. |
| Chronic Physical Problems/Diseases; Pertinent Development Information; Special Accommodations Needed; Special Instructions to Provider |

| Father's Full Name | Phone | Employer |
|---|---|---|
| Father's Employer's Address (Street Address) | | Father's Work Phone |
| Father's Home Address (Street Address)<br>(enter "Same" if address is the same as the child's) | | |
| Mother's Full Name | Phone | Employer |
| Mother's Employer's Address (Street Address) | | Mother's Work Phone |
| Mother's Home Address (Street Address)<br>(enter "Same" if address is the same as the child's) | | |
| Child's Physician | Office Address (Street Address)<br>City State Zip | Phone |
| Name of Child's Medical Insurance | | Policy Number |
| Name of Emergency Contact if Parent(s) Cannot Be Reached | Street Address<br>City State Zip | Phone |
| Name of Emergency Contact if Parent(s) Cannot Be Reached | Street Address<br>City State Zip | Phone |
| Person(s) Authorized to Pick Up Child (Appropriate custodial paperwork (custody order or other court order) shall be attached if a parent is not allowed to pick up the child) | | |

_____ _____ **(Valid for One Year)**
Parent Signature Date

**1st yr. review** _____ _____ _____
Parent Signature Date

**2nd yr. review** _____ _____ _____
Parent Signature Date

**3rd yr. review** _____ _____ _____
Parent Signature Date

# CHILD'S RECORD

## PROOF OF AGE AND IDENTITY (must be obtained from parent within 7 business days of child's first day of attendance)

| Names & Locations (City and State) of Previous Child Day Care Programs & Schools Attended | | | |
|---|---|---|---|
| Place of Birth | Birth Date | Birth Certificate Number | Date Issued |
| Proof of Age Other Than Birth Certificate* | | Date Documentation Viewed | Person Viewing Documentation |

## NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCY (if parent does not provide proof of child's age and identity within 7 business days of child's first day of attendance)

| Date of Notification | Name of Agency Notified | Name of Individual Notified |
|---|---|---|
| | | |

*Proof of age and identity may be verified by viewing one of the following: certified birth certificate; birth registration card; notification of birth, i.e., hospital, physician, or midwife record; passport; copy of the placement agreement or other proof of the child's identity from a child placing agency; original or copy of a record or report card from a public school in Virginia; signed statement on letterhead stationery from a public school principal or other designated official that assures the child is or was enrolled in the school; or child identification card issued by the Virginia Department of Motor Vehicles.

## EMERGENCY MEDICAL AUTHORIZATION

I authorize _____ to obtain immediate care and consent to emergency medical
Name of Licensed Provider
procedures upon, the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to _____ if an emergency occurs and I cannot be located immediately.
Name of Child

It is also understood that this agreement covers only those situations which are true emergencies and only when I cannot be reached. Otherwise I expect to be notified immediately.

_____ _____
Signature of Parent Date

**The child's Emergency Information and the Emergency Medical Authorization must be made available to a physician, hospital, or emergency responders in the event of a child's illness or injury.**

## ADDITIONAL DOCUMENTS REQUIRED FOR CHILD'S RECORD

____ Immunization and Physical Examination Record Form MCH213 F (signed by physician, physician's designee, or health official)

____ Information for Parents (signed by parent)

____ Policy for the Administration of Medications (signed by parent)

____ Liability Insurance Declaration (signed by parent)

____ Provisions of the Home's Emergency Preparedness and Response Plan (signed by parent)

**As Applicable:**

____ General Permission for Regularly Scheduled Trips (signed by parent)

____ Special Field Trip Permission (signed by parent)

____ Medication Consent (signed by parent) ***Valid for 10 days unless also signed by physician**

____ Permission to Participate in Swimming or Wading Activities (signed by parent) ***Valid for one year**

____ Injury Record(s)

**If Child with Special Needs is in Care:**

____ Staffing Recommendation for a Child with Special Needs (signed by parent, provider, and Licensing representative)

____ Individual Health Care/Special Needs (signed by licensed health care professional)

_____
Name of Child

# INFORMATION FOR PARENTS

**Before the child's first day of attendance, parents shall be provided in writing the following information about the family day home (as required by 22 VAC 40-111-70 of the Standards for Licensed Family Day Homes):**

| |
|---|
| Hours and Days of Operation: |
| Holidays or other scheduled times closed: |
| Telephone number where a message can be left for a caregiver: |
| Fees for care (including regular rate for care of this child, late fees, activity fees, returned check fees, etc.): |
| Payment of fees due on: |
| Check in and check out procedures (to include where and when provider will assume care such as at her home, at the school, at the bus stop; acceptable drop off/pick up procedures, etc.) |
| The family day home must notify the parent when the child becomes ill and the parent must arrange to have the child picked up as soon as possible if so requested by the home. |
| The parent must inform the family day home within 24 hours or the next business day after his child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life-threatening diseases, which must be reported immediately. |
| The child must be adequately immunized prior to admission and must receive additional immunizations as required by state law (unless parent provides proper documentation of medical or religious exemption). |
| Paid caregivers must report suspected child abuse or neglect according to § 63.2-1509 of the Code of Virginia; |
| Custodial parents have the right to be admitted to the family day home any time their child is in care (required by § 63.2-1813 of the Code of Virginia) |
| A pet or animal is present in the home: _____Yes _____No |
| Family day home will provide meals and snacks: _____Yes _____No<br>Other Information: |
| General daily schedule that is appropriate for the age of the enrolling child: (usual routine for provision of meals and snacks, naps, indoor play, outdoor play, etc.): |
| Discipline policies including acceptable and unacceptable discipline measures:<br>• Corporal punishment such as spanking is prohibited<br>• Is time out used with children other than infants and toddlers? _____Yes _____No<br>Other: |
| The following attachments signed by parent:<br>• Liability Insurance Declaration<br>• Policies for the Administration of Medication<br>• Provisions of the Emergency Preparedness and Response Plan |

## INFORMATION FOR PARENTS



Amount of time per week that an adult assistant or substitute provider instead of the provider is regularly scheduled to care for the child (such as when provider leaves each day to transport children): _____

Name of the adult assistant or substitute provider: _____

Policies for termination of care (to include any requirements for prior notice; fees if prior notice is not given by parents; general reasons for termination such as non-payment of fees, age of child, behavior of child, etc.):

A copy of the regulation, *Standards for Licensed Family Day Homes,* and additional information about the family day home, including compliance history that includes information after July 1, 2003 may be obtained from the following website: http://www.dss.virginia.gov/facility/search/licensed.cgi

**Providers must notify parents (required by 22 VAC 40-111-650):**

- In writing, within 10 business days after the effective date of the change when there is no longer liability insurance in force on the family day home operation (may use Liability Insurance Declaration Form);
- Daily about the child's health, development, behavior, adjustment, or needs
- Prior to when a substitute provider will be caring for the children (for provider's vacation, appointments, etc.)
- When persistent behavioral problems are identified and such notification shall include any disciplinary steps taken in response.
- Immediately when the child:
  - Has a head injury or any serious injury that requires emergency medical or dental treatment;
  - Has an adverse reaction to medication administered;
  - Has been administered medication incorrectly;
  - Is lost or missing; or
  - Has died.
- The same day whenever first aid is administered to the child.
- Within 24 hours or the next business day of the home's having been informed, unless forbidden by law, when a child has been exposed to a communicable disease listed in the Department of Health's current communicable disease chart. Life-threatening diseases must be reported to parents immediately. The provider shall consult the local health department if there is a question about the communicability of a disease.
- In writing, whenever there are changes in the home's emergency preparedness and response plan (that is, any changes to the Provisions of the Emergency Preparedness and Response Plan given to parents prior to the child's first day of attendance.
- Whenever the child will be taken off the premises of the family day home, before such occasion (except in emergency evacuation or relocation situations) and the provider will have written parental permission
- As soon as possible of the child's whereabouts if an emergency evacuation or relocation is necessary.

_____ _____

Parent Signature Date

# Policy for the Administration of Medications

**(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-60 B 8)**

| Provider's Name (please print): | Name of Family Day Home: |
|---|---|
| | |

I have made the following decision regarding the administration of medications to a child in my family day home:

☐ I (or other caregivers) **WILL NOT** administer any medications – prescription or non-prescription medication.

☐ I (or other caregivers) **WILL** administer **ONLY** prescription medication.

☐ I (or other caregivers) **WILL** administer **ONLY** non-prescription medication.

☐ I (or other caregivers) **WILL** administer **BOTH** prescription and non-prescription medication.

☐ I (or other caregivers) **WILL** administer **ONLY** non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellant.

## Authorized Caregivers to Administer Prescription and Non-Prescription Medications

Only a caregiver who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications and is listed as a medication administrator in this document will be permitted to administer prescription medications and non-prescription medication (except non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellant) in my family day home.

Medication administrators will administer prescription medications in accordance with the physician's or other prescriber's instructions and in accordance with the standards of practice in the MAT training.

Medication administrators will administer non-prescription medications at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child.

I understand that any individual listed in this section as a medication administrator is approved to administer prescription medications using the following routes: topical, oral, inhaled, eye, and ear, medication patches and epinephrine using an auto-injector device.

I understand that if a child in my family day home requires prescription medication to be administered rectally, vaginally, by injection or by another route not listed above, I will follow the procedures outlined in the MAT training for children with special health care needs.

## Medication Administrator(s)

Current MAT certificates (or documentation of licensure to administer prescription medications), current age-appropriate first aid certificates, and current CPR certificates for the caregivers listed below will be kept in the caregivers' records and be available upon request.

Caregiver Name: _____

Caregiver Name: _____

Caregiver Name: _____

## Confidentiality Statement

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

## ADA Statement

I understand the provisions of the Americans with Disabilities Act. If any child enrolled in my family day home now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the family day home to meet the needs of the child (for further information on ADA seek legal counsel and/or go to the following website: www.usdoj.gov/crt/ada/chcaflyr.htm). If my family day home can meet the needs of the child without making a fundamental alteration to the program and the child will need regular or emergency medication, I will ensure that I have a caregiver in my family day home who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications.

## Provider Statement

I understand that it is my responsibility to follow my *POLICY FOR THE ADMINISTRATION OF MEDICATION* and all health and infection control regulations applicable to my family day home.

I will verify and document the credentials for all new caregivers before the caregiver is allowed to administer prescription or non-prescription medications (except non-prescription topical skin products) to any child in my family day home.

My *POLICY FOR THE ADMINISTRATION OF MEDICATION* will be made available to parents at enrollment, whenever changes are made and upon request.

**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 Signature: | Date: |
| Parent's Signature: | Date: |

MODEL FORM

Child's Name _____

# LIABILITY INSURANCE DECLARATION

THIS FORM COMPLIES WITH THE REQUIREMENTS OF § 63.2-1809.1 OF THE CODE OF VIRGINIA AND MUST BE MAINTAINED ON FILE IN THE FAMILY DAY HOME AT ALL TIMES WHILE THE CHILD IS IN ATTENDANCE AND FOR 12 MONTHS AFTER THE CHILD'S LAST DAY OF ATTENDANCE.

**I have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Social Services ($100,000 per occurrence and $300,000 aggregate).**
**_____ Yes _____ No**

**I, _____, acknowledge having received the**
(Signature of parent or guardian)
**above-referenced notification on _____.**
(Date)

---

☐ **I no longer have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Social Services effective _____.**
(Date)

**I, _____, acknowledge having received the**
(Signature of parent or guardian)
**above-referenced notification on _____.**
(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 Mother or Legal Guardian: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Name of Father or Legal Guardian: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

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

| Condition | Yes | Comments | Condition | Yes | Comments |
|---|---|---|---|---|---|
| Allergies (food, insects, drugs, latex) | | | Diabetes | | |
| Allergies (seasonal) | | | Head 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, etc.):

_____

_____

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

_____

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

Please provide the following information:

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

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

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

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

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

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

MCH 213 G revised 10/2010

**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 <2 years of age | 1 | 2 | 3 | 4 | |
| Measles, Mumps, Rubella (MMR vaccine) | 1 | 2 | | | |
| *Measles (Rubeola) | 1 | 2 | Serological Confirmation of Measles Immunity: | | |
| *Rubella | 1 | | Serological Confirmation of Rubella Immunity: | | |
| *Mumps | 1 | 2 | | | |
| *Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used | 1 | 2 | 3 | | |
| *Varicella Vaccine | 1 | 2 | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | |
| Hepatitis A Vaccine | 1 | 2 | | | |
| Meningococcal Vaccine | 1 | | | | |
| Human Papillomavirus Vaccine | 1 | 2 | 3 | | |
| Other | 1 | 2 | 3 | 4 | 5 |
| Other | 1 | 2 | 3 | 4 | 5 |

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

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

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

**TB Risk Assessment**: ☐ No Risk ☐ Positive/Referred

Mantoux results: _____ mm

**Physical Examination**

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

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

**EPSDT Screens Required for Head Start – include specific results and date:**

Blood Lead: _____ Hct/Hgb _____

**Developmental Screen**

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

**Hearing Screen**

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

| | 1000 | 2000 | 4000 |
|---|---|---|---|
| R | | | |
| L | | | |

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

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

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

**Vision Screen**

☐ With Corrective Lenses (check if yes)

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

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

**Dental Screen**

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

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

**Summary of Findings** (check one):

☐ **Well child; no conditions identified of concern to school program activities**

☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____

Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epi pen ☐ other: _____

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

___ **Restricted Activity** Specify: _____

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

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

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

**Other Comments:** _____

**Health Care Professional's Certification** (Write legibly or stamp):

**Name**: _____ **Signature:** _____ Date: ___/___/_____

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

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

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# AUTHORIZATION TO APPLY A NON-PRESCRIPTION TOPICAL SKIN PRODUCT

**(Such as Sunscreen, Diaper Ointment and Lotion, Oral Teething Medicine and Insect Repellant as required by 22 VAC 40-111-750 of the Standards for Licensed Family Day Homes)**

_____ has my permission to apply the following
*(Name of Provider)*
non-prescription topical skin product to my child,

_____.
*(Name of Child))*

Product Name: _____

Known Adverse Reactions (if any): _____

_____

- The product must be in the original container and, if provided by the parent, labeled with the child's name
- Manufacturer's instructions for application must be followed
- Parents must be informed immediately of any adverse reaction
- The product must not be used beyond the expiration date of the product
- Sunscreen must have a minimum sunburn protection factor (SPF) of 15

This authorization is effective until: _____ (the effective period must not exceed one calendar year from the date of the parent's signature below).

Parent's Signature: _____ Date: _____

# GENERAL PERMISSION FOR REGULARLY SCHEDULED TRIPS

**(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-980 A)**

| | |
|---|---|
| Child's Name | |
| Routine Trip Destination(s) | |

Mode of Transportation:

___ Walking

___ School bus

___ Public transportation

___ Provider vehicle _____ Name of Driver

___ Other vehicle _____ Name of Driver

**I grant permission for my child to participate in the regularly scheduled trips described above.**

_____ _____

**Parent's Signature** **Date**

# SPECIAL FIELD TRIP PERMISSION

**(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-980 B)**

| | |
|---|---|
| Child's Name | |
| Destination of Field Trip | |
| Date of Field Trip | |
| Duration of Field Trip | From:_____ To:_____ |

Mode of Transportation:

___ Walking

___ School bus

___ Public transportation

___ Provider vehicle _____
Name of Driver

___ Other vehicle _____
Name of Driver

**I grant permission for my child to participate in the field trip described above.**

_____ _____

**Parent's Signature** **Date**

# PERMISSION TO PARTICIPATE IN SWIMMING AND WADING ACTIVITIES

**Licensing standards at 22 VAC 40-111-660 require:**

- **A parent's written permission before a child participates in swimming or wading activities;**
- **A parent's written statement advising of the child's swimming skills before the child is allowed in water above the child's shoulder height; and**
- **When one or more children are in water more than 2 feet deep -**
  - **At least 2 caregivers to be present and able to supervise the children; and**
  - **An individual (may be one of the caregivers) currently certified trained in basic water rescue, lifeguarding, or water safety.**

| | |
|---|---|
| **My child is a:** ☐ **Swimmer** ☐ **Non-swimmer**<br><br>**Other Information on Child's Swimming Skills (if applicable):** | |
| **I give permission for my child to participate in swimming/wading activities:**<br><br>_____<br>**Parent's Signature** | **Date of Permission (valid for one year)** |

VDSS MODEL FORM - FDH

# INJURY RECORD

(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-840)

**Date of Injury:** _____ **Time of Injury:** _____

**Name of Injured Child:** _____

**Type and Circumstance of the Injury:**

_____

_____

_____

_____

_____

**Caregiver(s) Present:** _____

_____

**Action Taken:**

_____

_____

_____

_____

**Date Parent(s) Notified:** _____ **Time of Notification:** _____

**Method of Notification:** _____

**Future Action to Prevent Recurrence of Injury:**

_____

_____

_____

_____

_____

**Caregiver Signature:** _____

**Caregiver Signature:** _____

**Parent Signature:** _____

**Staff and parent signature OR two caregiver signatures are required.**

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**NOTE: The parent must be notified IMMEDIATELY if a child has a head injury or any serious injury that requires emergency medical or dental treatment. The parent must be notified the same day whenever first aid is administered to the child. Providers must record the injury in the child's record on the day the injury occurs.**

032-05-0043-01-eng

# Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

| 1. Child's first and last name: | 2. Date of birth: | 3. Child's known allergies: |
|---|---|---|
| 4. Name of medication (including strength): | 5. Amount/dosage to be given: | 6. Route of administration: |

7A. Frequency to be administered: _____

*OR*

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

*AND/OR*

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

*AND/OR*

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

| 14. Date consent form completed: | 15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid): |
|---|---|
| 16. Prescriber's name (please print): | 17. Prescriber's telephone number: |

18. Licensed authorized prescriber's signature:
Required for Long-Term medication or when dosage directions state "consult a physician".

**This is a double-sided form**

## Written Medication Consent Form

## PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

| |
|---|
| 19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No<br>Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____ |
| 20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name) |
| 21. Parent or legal guardian's name (please print): / 22. Date authorized: |
| 23. Parent or legal guardian's signature: |

## CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

| | | |
|---|---|---|
| 24. Provider/Facility name: | 25. Facility telephone number: | 26. (leave blank) |
| 27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program. | | |
| 28. Authorized child care provider's name (please print): | 29. Date received from parent: | |
| 30. Authorized child care provider's signature: | | |

## ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

| |
|---|
| 31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed. |
| 32. Parent or Legal Guardian's Signature: |

## LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

| |
|---|
| 33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child._____ |
| |
| |
| 34. Licensed Authorized Prescriber's Signature: |
| 35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.<br>DATE:_____<br>By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled. |
| 36. Licensed Authorized Prescriber's Signature: |

**This is a double-sided form**