SUPERVISION POLICY

Supervision Policy for Ana Vasquez
(Provider's Name)

- The family day care home provider will ensure that all persons responsible for the care of children will supervise all children based on their age, needs, and abilities at all times.
- Children will always be kept within actual sight and sound supervision of the family day care provider and all responsible persons, and will be near enough to intervene if needed.

Supervision Guidelines
✓ Children will ***never*** be left alone or unattended. ✓ Children must be supervised, when sleeping. ✓ Caregivers will always ensure that they can hear and/or see infants while they are sleeping. ✓ Caregivers will know children's activities ***at all times***; inside and outside of the home. ✓ Equipment such as cribs, high chairs, and swings, should be limited to use for intended purposes: sleep, feeding and limited exercise. ✓ Infants and toddlers will not be confined for long periods of time. ✓ Infants will be protected from older children.

Provider's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

**This policy is not a requirement of Arlington County Code Chapter 59 Family Day Care Homes

PREVENTION OF SHAKEN BABY SYNDROME/ ABUSIVE HEAD TRAUMA & SAFE SLEEP POLICY

Parent or Guardian Acknowledgement Form

I, the parent/guardian of _____
(Child's Name)

acknowledge that I have read and received a copy of the family day care home's Shaken Baby Syndrome/Abusive Head Trauma Policy.

Provider's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____

PREVENTION OF SHAKEN BABY SYNDROME/ ABUSIVE HEAD TRAUMA & SAFE SLEEP POLICY

TRAINING

- The provider, substitute provider and assistants will be trained on shaken baby syndrome/abusive head trauma and safe sleep policies and practices.
- The provider will review *The Period of Purple Crying* prevention program materials that are provided by Arlington County Department of Human Services, Child and Family Services Division.
- The provider will ensure that any staff who cares for and has direct contact with children will review *The Period of Purple Crying* prevention program materials.

APPLICATION PLAN FOR CAREGIVERS AND PARENTS:

- The family day care home provider shall review this policy with current substitute providers, assistants and parents/guardians within thirty (30) days of adopting this policy.
- The family day care home provider shall review this policy with all new substitute providers and assistants prior to working alone with children and within seven (7) days of hire.
- A copy of this policy shall be given and explained to the parents/guardians of newly enrolled children on or before the first day of enrollment.
- Substitute providers, assistants and parents/guardians will sign an acknowledgement form of receipt of this policy that includes the individual's name, signature, and the date the individual signed the acknowledgement.
- The child care provider shall keep the SBS/AHT acknowledgement form in each staff member and child's record.

Policy Effective Date: _____

This policy was reviewed and approved by: _____
(Family Day Care Home Provider)

PREVENTION OF SHAKEN BABY SYNDROME/ ABUSIVE HEAD TRAUMA & SAFE SLEEP POLICY

In addition, the provider will:

- Allow caregivers who feel they may lose control to have a short break away from the children.
- Provide support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.

SAFE SLEEP

Safe sleeping practices and prevention strategies for sudden infant death syndrome:

- Each infant will be provided with an individual crib.
- Consumer Product Safety Commission (CPSC) safety-approved cribs will only be used for infants.
- Infants will be placed flat on their backs to sleep unless otherwise ordered by a written statement signed by the child's physician.
- A firm surface, such as a mattress will be used for infant sleeping. The mattress will fit snugly to the crib and will be covered with a fitted sheet.
- Soft bedding, such as pillows, quilts, and comforters will not be used in the infant's sleeping area.
- Crib sides will always be up with the fastenings secured when occupied.
- An infant who falls asleep in a play space other than their crib, will be moved promptly to their designated sleeping space.
- Smoking will not be allowed in the home while children are in care.
- Crib bumper pads will not be used.

Supervision of sleeping infants:

- Sleeping infants will be placed in cribs within sight and hearing supervision of the provider or staff at all times.
- The provider or staff will visibly check on sleeping infants at least once every 15 minutes if the infant is sleeping in a separate area. The provider will use a baby monitor for additional monitoring of sleeping infants between each 15-minute interval.
- Infants will spend limited time confined in a crib, play pen, high chair or other confining piece of equipment.

PREVENTION OF SHAKEN BABY SYNDROME/ ABUSIVE HEAD TRAUMA & SAFE SLEEP POLICY

Provider's Name: Vasquez Ana

It is important to provide infants with a safe place to grow and learn. I have established this policy to prevent, recognize, respond to and report shaken baby syndrome and abusive head trauma (SBS/AHT), as well as implement safe sleep practices. As a family day care home provider, I understand the importance of ensuring the health and safety of children, providing quality care and educating families.

Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT)

Procedure

Recognizing SBS/AHT:

- Children will be observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake, loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruising, poor feeding or sucking, no smiling or vocalization, inability of eyes to track and/or decreased muscle tone.

Responding to SBS/AHT:

- If SBS/AHT is suspected, the provider and/or assistant will:
  - Call 911 immediately upon suspecting SBS/AHT.
  - Call the parents or guardians.
  - If the child has stopped breathing, a trained staff will begin pediatric CPR.

Reporting SBH/AHT:

- Instances of suspected maltreatment of a child are reported to Arlington County Child Protective Services by calling 703-228-1500 or by calling the toll-free number of the Child Abuse and Neglect hotline at 1-800-552-7096.

Prevention strategies for caregivers to cope with a crying child:

- Check the child to determine if they are hungry, tired, sick or need a diaper change.
- Rock the child, hold the child close or walk with the child.
- Sing or talk to the child in a soothing voice.
- Rub the child's back, chest, or tummy gently.
- Provide the child with a pacifier, rattle or toy.
- Take the child for a ride in a stroller.
- Play soft music.

EMERGENCY MEDICAL CONSENT

Parent/Guardian: _____
Address: _____
Telephone: (___) _____

Name and address of relative, friend or otherwise responsible person to contact in case parents cannot be reached:
Name: _____
Address: _____
Telephone: (___) _____

EMERGENCY MEDICAL AUTHORIZATION

I authorize _____ to obtain immediate consent and care to
(Family Day Care Provider's Name)
emergency medical procedures upon, the hospitalization of, the performance of necessary diagnosis tests upon, the use of surgery on, and/or the administration of drugs to _____if an emergency occurs and I cannot be located immediately.
(Child's Name)

I further understand that this agreement covers only those situations which are true emergencies and only when I cannot be reached.

Physician / Clinic: _____

Address: _____

Hospital: _____

_____ _____
PARENT'S SIGNATURE **DATE**

Name of Insurance Company / Medicaid: _____
Address: _____ Telephone: (___) _____
Policy / Medicaid Number: _____

List Of Supplies

Please be sure to label all items as this will avoid confusion in the future. Thank you!

- Diapers
- Baby Wipes
- Breast Milk or Formula
- Bibs
- Receiving Blankets (at least 5 per week)
- Burp Cloths
- Rash Cream
- Blankets (at least 2 large blankets)
- Crib Sheet (optional)
- Sleeping Sack
- Extra Clothes
- Dishes, Cups, & Eating Utensils (if needed)
- Baby Bottles
- Pacifiers (if needed)
- Meals (because of differences in allergies, we do not provide meals)

ALL meals are required to include the date that they were received. Any additional items are welcome!

BEHAVIOR MANAGEMENT PLAN

Behavior Management Plan Ana Vasquez
(Provider's Name)

This family day care home will practice positive reinforcement for discipline and behavior management as follows:

- Discipline will be individualized and consistent for each child; using constructive methods for establishing freedom within limitations for behavioral guidance with an awareness of the developmental needs of the child.
- Discipline will be directed towards teaching the child acceptable behavior and self-control.
- The family day care home provider and/or assistant(s) will only use positive methods of discipline and guidance encouraging self-esteem, self-control, and self-direction, to include the following:
    - Modeling appropriate behavior for the children.
    - Modifying the family day care home environment in order to prevent problems before they occur.
    - Listening to the children; respecting their needs, desires, and feelings.
    - Providing alternative activities for inappropriate behavior to the children.
    - Using a brief supervised separation or time out from the group, when appropriate for the child's age and development, and limited to no more than one minute for each year of the child's age. Time out will not be used with infants or toddlers.

- The family day care provider and/or assistant(s) will not use corporal punishment or any humiliating or frightening methods of discipline. The following types of discipline and guidance are **PROHIBITED:**
    - Physical punishment or threats of physical punishment, such as but not limited to striking, shaking, twisting, squeezing or rough handling, biting a child; humiliating, ridiculing, rejecting, or yelling at a child; or subjecting a child to harsh, abusive or profane language
    - Physical restraint of a child or isolating a child in a confined space.
    - Forcing a child to assume an uncomfortable position or exercise as punishment.
    - Separating a child from the group in which the child is not in direct supervision of staff.
    - Punishment associated with food, naps, or toilet trainings. *Any effort toward toilet training will be made in consultation with and consent of the child's parent(s).*
    - Refusal of food or being deprived of snacks and meals as a form of discipline.
    - Any methods of discipline or interaction which frightens, humiliate or are demeaning to the child.

Provider's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

FAMILY DAY CARE HOME
INFORMATION FOR PARENTS

Before the child's first day of attendance, parents shall be provided in writing the following information about the family day care home.

Child's Name:	
Days and hours of Operation: Monday – Friday 8:00 am – 5:30 pm	Holidays and other scheduled times closed: See attached
Payment rate of: $_____ per ☐hour ☐day ☐week ☐month Payments to be made: ☐daily ☐weekly ☐monthly	Other payment arrangements: Activity fee: $_____ Late fee: $_____ Returned check fee: $_____ Other: $_____
Telephone number where a message can be left for a caregiver: (703)-920-0399	
Check in and check out procedures (to include where the provider will assume care, acceptable drop off/pick up procedures): I will assume care of your child when the parents drop-off at my door. The child is in the care of the parents when they are picked up.	

Provisions:

- The family day care provider will notify the parent(s) when the child becomes ill and that the child should be picked up as soon as it is feasible for the parent to do so.
- The parent must inform the family day care home within 24 hours or the next business day after his or her child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for a life-threatening disease, which must be reported immediately.
- The child must be adequately immunized prior to admission and must receive additional immunizations as required by state and county law (unless parent provides proper documentation of medical or religious exemption).
- The family day care provider, assistant(s) and substitute provider must report suspected child abuse and neglect according to § 63.2-1509 of the Code of Virginia.
- Custodial parents have the right to be admitted to the family day care home any time the child is in care as required by § 63.2-1813 of the Code of Virginia.
- Parent(s) will be encouraged by the family day care provider to visit the home while it is in operation.

A pet or animal is present in the home: ☐Yes ☐No

If yes, the pet or animal is: ☐allowed in the day care area ☐NOT allowed in the day care area

The family day care home will provide meals and snacks: ☐Yes ☒No

Discipline policies including acceptable and unacceptable discipline measures:

- Physical punishment is prohibited
- Is time out used with children other than infants and toddlers? ☐Yes ☒No
- Other:

***Please refer to the Family Day Care Home's Behavior Management Plan**

FAMILY DAY CARE HOME
INFORMATION FOR PARENTS

Amount of time per week that an adult assistant or substitute provider instead of the provider is scheduled to care for the child (example: when the provider leaves to transport children, run errands, ect...): Full time

Name of the adult assistant or substitute provider: _____

The family day care home provider must notify parents of the following as required by § 59-40:

- Daily written or oral information about the child's health, development, behavior, adjustments, or needs
- Prior notice when a substitute provider will be caring for the children
- 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
  - Had died.
- The same day whenever first aid is administered to the child.
- When a child has been exposed to a communicable disease listed in the Department of Health's current communicable disease chart, parents must be notified within 24 hours or the next business day of the family day care home having been informed, unless forbidden by law. 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.
- Immediately of any confirmed or suspected allergic reaction and the ingestion of prohibited food even if a reaction did not occur.
- In writing of changes in the family day care home's emergency preparedness and response plan.
- Before such occasion, whenever the child will be taken off the premises of the family day care home (except in emergency evacuation or relocation situations) and the provider must have written parental permission.
- As soon as possible of the child's whereabouts if an emergency evacuations or relocation is necessary.

Policies for termination of care (to include requirements for advance notice, fees if advance notice is not given by parents, termination for non-payment of fees, behavior of child, ect...):

Termination of care will be made at my discretion

A copy of the regulation, Arlington County Code, Chapter 59 Family Day Care Homes, and additional information about the family day care home may be obtained from the following website:
http://www.family.arlingtonva.us/child-care/

The family day care provider shall obtain the parent's signed acknowledgement of the following attachments:

- Liability Insurance Confirmation
- Behavior Management Plan
- Emergency Preparedness and Response Plan
- Decision to Administer Medication
- Medication Administration Policies
- Prevention of Shaken Baby Syndrome Policy

Parent's Signature: _____ Date: _____

CHILD'S RECORD

- **INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.**
- **THE COMPLETED FORM MUST BE KEPT IN THE CHILD'S RECORD AND THE FIRST PAGE UPDATED ANNUALLY.**
- **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) (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) (enter "Same" if address is the same as the child's)			
Child's Physician	Office Address (Street Address) City / State / Zip		Phone
Name of Child's Medical Insurance			Policy Number
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address City / State / Zip		Phone
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address 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)

FAMILY DAY CARE
INFORMATION AND AGREEMENT FORM

Child's Name: _____ Nickname : _____
Address: _____ Telephone: _____
Birthdate: _____ Date Started Care: _____

==========

Mother's Name: _____ Home Telephone: _____
Address: _____
Employer: _____ Work Telephone: _____
Father's Name: _____ Home Telephone: _____
Address: _____
Employer: _____ Work Telephone: _____

Name of person having legal custody of child: (This information is recommended, but not required)

_____

Name of persons to contact if parents can not be reached:
1. Name: _____ Telephone: _____
Address: _____
2. Name: _____ Telephone: _____
Address: _____
Persons authorized to pick up this child: _____
Persons NOT authorized to pick up or visit this child _____
Physician's Name: _____ Telephone: _____
Physician's Address: _____
Information about child's health, allergies, food habits, etc.: _____

_____

Child Development Information:

Child's interests: _____
Favorite toys and activities: _____
Fears: _____
Toileting habits: _____
Previous day care experience: _____
Method of discipline: _____
(Providers are not permitted to use physical punishment or any humiliating or frightening method of discipline or to deprive a child of meals or snacks)

The parent and provider agree on the following:

Terms of Care: Days: _____ Hours: _____
Payment rate of $_____ per ☐ hour ☐ day ☐ week ☐ month
Payments to be made ☐ daily ☐ weekly ☐ monthly
Other agreements: (Such as sick pay, late fees, holiday, vacation) _____

_____

The parent will supply: ☐ Diapers ☐ Wipes ☐ Toys ☐ Food ☐ Bottles ☐ Change of Clothes
The provider will supply: ☐ Diapers ☐ Wipes ☐ Toys ☐ Food ☐ Bottles ☐ Change of Clothes
The provider will serve to the child: ☐ Breakfast ☐ Morning Snack ☐ Lunch ☐ Afternoon Snack ☐ Dinner

The parent and provider agree to these terms and will adhere to items listed on back of this page.

Parent's signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Provider - White copy - Parent -Yellow copy

(See Back)

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)

Medication Administration – Decision to Administer

(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:
Ana Vasquez	My Little Shine Home Daycare

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

- [x] 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** EpiPens and prescription topical creams and ointments.
- [ ] 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:

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:** _____

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: 8:00 am - 5:30pm Monday - Friday
Holidays or other scheduled times closed: See attached
Telephone number where a message can be left for a caregiver: (703)-920-0399
Fees for care (including regular rate for care of this child, late fees, activity fees, returned check fees, etc.): See attached
Payment of fees due on: Monday
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.) I will assume care of your child when parents drop-off at my door. The child is in the care of parents when they are picked up.
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 __X__No 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.): See attached
Discipline policies including acceptable and unacceptable discipline measures: • Corporal punishment such as spanking is prohibited • Is time out used with children other than infants and toddlers? _____Yes __X__No Other:
The following attachments signed by parent: • Liability Insurance Declaration • Policies for the Administration of Medication • 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): Full time

Name of the adult assistant or substitute provider: Felicidad Vasquez

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.):

Termination of care will be made at my discretion.

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 _____

VDSS MODEL FORM - FDH

PROVISIONS OF THE EMERGENCY PREPAREDNESS AND RESPONSE PLAN

Before the child's first day of attendance, parents must be informed of the provisions in the home's Emergency Preparedness and Response Plan (Standards for Licensed Family Day Home 22 VAC 40-111-70 A 16).

To the Parent (s) of _____ *(child's name)*:

This letter is to assure you of our concern for the safety and welfare of children attending My Little Shine Home Daycare *(insert name of family day home).*

Our Emergency Plan provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation* Children are evacuated to a safe area near the home in the event of a fire, etc.

- *In-place sheltering* Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the home is the best immediate response.

- *Relocation* Total evacuation of the home may become necessary if there is a danger in the area. In this case, children will be taken to a relocation site at Arlington Baptist Church 1950 S. Monroe St. Arlington, VA 22204 (703)-979-7344 *(insert name/physical address of relocation site)*

We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information.

We will have your contact information with us and you will be contacted as soon as possible following any emergency action so that arrangements can be made for you and you child to be safely reunited.

In your child's record at this home are the names of persons you have authorized to pick up your child if you not able to do so. Please ensure that only those persons you have authorized attempt to pick up your child.

We specifically urge you **not** to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, we ask for your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, please let us know.

_____ _____

Parent Signature Date