Emmanuel Lutheran Preschool
2589 Chain Bridge Rd. Vienna, VA 22181
"Let the little children come to me" Luke 18:16

REGISTRATION INFORMATION

The 2011-2012 registration packet consists of this information sheet with a class and fee schedule, a registration application, the enrollment information form and an emergency contact and authorization form. **EVERY CHILD WISHING TO ENROLL MUST HAVE HIS/HER OWN REGISTRATION FORM.** All applications will be accepted in the office **before** Wednesday, January 26th at 12 Noon for the lottery the next day. All papers submitted after that time will be processed at the END of the lottery. Registration papers received after the lottery will be placed first come, first served basis.

The Lottery will process Priority In-House registrations first then the General Public registrations. These groups are as follows:

1. Children of ELP Staff, church staff & active ELP Board members
2. Teacher placement recommendations
3. Currently enrolled children & their siblings (1 number per family)
4. Children of members of Emmanuel Lutheran Church, not currently enrolled
5. Siblings of Preschool alumni
6. General Public Registrations

The Process
A registration fee paid by check only is $80 for single applicants and $70 for each additional child. Please complete a registration form for each child.

When forms are given to the office we will assign a tracking number and staple a card with that number to the form. Family applications of more than one child are assigned one number. All registrations received by 12 Noon Wednesday, January 26th will be sorted into groups according the groups outlined above. A committee comprised of the Preschool Director, Program Director, and many of our ELP board members will conduct the lottery. Numbers from the first group will be placed in a basket and we'll randomly pick numbers to assign those children to classes. If the class is full, we will place the child on the wait list for the class. We fill classes based on number of applications received, boy/girl ratios, teacher recommendations, as well as the need to place siblings in school on the same days. **Every child currently enrolled and applying on time at ELP will receive placement in a class for the next year.** We do not confirm teachers in classes, just that your child has been enrolled. Class lists are finalized and published by mid August.

Once group #1 is processed and placed in classes, we will follow the same procedure for each of the remaining groups as outlined above. We will send you a letter confirming your child's placement.

The registration fee is non-refundable and will only be returned if your child is not offered placement in Emmanuel Lutheran Preschool. If we cannot place your child in a class, we will place him/her on the wait list and return your registration check. Please call the Emmanuel Lutheran Preschool office at (703) 938-6187 if you need any further information.

PARENT INFORMATION SHEET

EMMANUEL LUTHERAN PRESCHOOL
2589 Chain Bridge Road
Vienna, VA 22181
(703) 938-6187 or emmanuelpreschool@verizon.net

TUITION & FEE SCHEDULE 2011-2012
(All Classes 9:00am-12:00Noon)

REGISTRATION FEE: $80 first child and $70 each additional child

2 Day 2-1/2's Class – Mon/Tues or Thurs/Fri – 11 children/3 teachers
Must be 2-1/2 (30 mos.) by September 30 of the current school year
One-time Activity Fee - $40.00
Monthly Tuition Payment - $170

3 Day 3's Class – Mon. to Wed or Wed. to Fri. – 12 children/2 teachers
Must be 3 by September 30 of current school year
One-time Activity Fee - $50.00
Monthly Tuition Payment - $265

4 Day 3's Class Mon-Thurs (including Above and Beyond) up to 12 children/ 2 teachers *
One time Activity Fee-$50
Monthly Tuition payment-$355

4 Day 4's Class – Tues. through Fri. Classes - 12 to 18 children/2 teachers
Must be 4 by September 30 of current school year
One-time Activity Fee - $70.00
Monthly Tuition Payment - $360

5 Day 4s Class Mon-Fri (including Super Science)up to 20 children/ 2 teachers *
One time Activity Fee- $70
Monthly Tuition Payment-$450

Your registration fee must be submitted with your Application for Enrollment/ Registration Form and proof of identity (birth certificate or passport). Without exception, if offered a place in our school, the registration, activity fee, and first tuition payment are nonrefundable.
For families new to Emmanuel, the first tuition payment is due March 1, 2010. Returning preschool families will pay their activity fee and first tuition payment on

Registration Application

Office Use Only:

EMMANUEL LUTHERAN PRESCHOOL
2589 Chain Bridge Road
Vienna, Va. 22181
703-938-6187
emmanuelpreschool@verizon.net

Application #_____
Lottery #_____
Registration ($80.00)
2nd Child ($70)
Check #_____
Date_____

PLEASE COMPLETE BELOW:

Child's Name:_____
Date of Birth: _____ Boy/Girl _____
Are parents Church Employees?_____
Emmanuel Lutheran Church Members?_____
Is the Child Currently Enrolled?____ Which Class?_____
Did any other children in the family attend this preschool now or in the past?
If so/when/which class?_____

PLEASE INDICATE YOUR CLASS PREFERENCE (i.e. #1, #2):

2s Program (2 by 3/31/11) Mon/Tues_____ or Thurs/Fri_____

3s program (3 by 9/30/11) MTW____ WTW____MTWTh (including Above & Beyond)____

4s program (4 by 9/30/11) TWThF_____ MTWThF (including Super Science)_____

Note: If you do not receive a class placement in the lottery, your name will automatically be placed on the wait list.

Application Checklist:
This Registration Application
Enrollment form- both sides with signature
Emergency contact/ Authorization form including insurance information
Birth certificate to show office
Registration Fee

Enrollment Information 2011-2012

Child's Full Name:_____ Boy/ Girl

Name to be called in class_____Date of Birth:_____

Child speaks English: fluently__ a little__ not at all__ Language at home_____

Address:_____City_____zip_____

(Please only fill in information that is not listed above)

Mother: Name_____ Home Phone _____
Address _____Cell Phone _____
_____Work Phone _____
Employer _____e-mail_____

Father: Name _____ Home Phone_____
Address_____Cell Phone_____
_____Work Phone_____
Employer_____e-mail_____

Other children in the family or other persons living in the household
Names and ages _____

_____

Diagnosed Allergies – yes or no (circle) Type_____

Response Required---none____epi-pen____other_____

Action to be taken in an emergency_____

Pertinent Developmental/ Chronic Physical Information_____

_____

Does this child have an IEP? _____ If yes, please provide the office with a copy

Special accommodations to be aware of?_____

Previous or current child day care programs and/or schools attending:_____

_____

Please complete and sign other side *

Please read and sign below.

CHILD'S NAME:_____

The registration fee must be returned with Registration Form and Application for Enrollment. Without exception, if offered a place in the school the registration, activity fee and first tuition payment are nonrefundable. The activity fee and first (September) tuition payment are due March 1, 2011 for families new to Emmanuel. For returning families, the activity fee and first (September) tuition payment are due May 1, 2011. Tuition received after the 7th of that month will be deemed late and will incur a $20 late fee. If your first payment is not received by the 15th, we will not be able to hold the place for your child. The next monthly tuition payment is due September 1. As long as the child is enrolled, tuition must be paid whether or not the child is in attendance. Tuition refunds for other months must be requested through the Emmanuel Lutheran Preschool Board at a regularly scheduled meeting. They may be granted only if the space is filled with no loss in revenue to the school. The Health Form, Emergency Authorization Form, and proof of identity shown to the registrar (birth certificate or passport) This is required by the Commonwealth of Virginia and Fairfax County. Your child will not be able to begin school without the completed forms. The Health form should be updated should your child receive additional vaccines. It is understood that EMMANUEL LUTHERAN PRESCHOOL will not be responsible for any illness that the child named on the Registration Form may contract. The preschool will notify the parent as soon as possible if the child becomes ill. It is also understood that parents will notify the preschool when any member of the household is sick with a contagious illness as this is a Virginia State Licensing requirement.

I hereby give my consent to EMMANUEL LUTHERAN PRESCHOOL or anyone on its behalf to secure and provide any medical or other attention that is necessary or urgent, and I further agree to pay for any medical or any other expenses incurred on behalf of the above named child. EMMANUEL LUTHERAN PRESCHOOL is insured with Brotherhood Mutual Insurance Co. of National Church Group Insurance Agency, Inc.; P.O. Box 4480; Leesburg, VA 22075.

We agree to abide by all rules and guidelines set out in the ELP Parent Handbook. It is understood that each child must be toilet-trained for the 3 and 4 year old classes. It is also agreed that if it is found that the child fails to cooperate satisfactorily with the school program, or if tuition payments fall two (2) months in arrears, said child's name will be withdrawn from ELP enrollment. EMMANUEL LUTHERAN PRESCHOOL does not discriminate on the basis of race, color, religion, national or ethnic origin. It is also agreed that all applications for enrollment in EMMANUEL LUTHERAN PRESCHOOL are subject to the approval of the ELP Board.

Permission to photograph child during school activities. Yes _____ No_____
Permission to include name and address in the class directory. Yes _____ No_____

We understand our total financial commitment for the 2011-2012 school year is: **(Please complete this section)**

Monthly Tuition $ _____ x 9 mos. $ _____
Registration fee _____
One-Time Activity Fee _____
Total Yearly Financial Commitment $_____

Parent Signature_____date_____

****

OFFICE USE ONLY
Identity Verification

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency, record from a public school in Virginia, or certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented. 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.

Birth Certificate Number # _____Child's Full Name:_____

Date of Birth:_____ Boy/Girl

Place of Birth: _____ Date Filed/Issued:_____

Emmanuel Lutheran Preschool 2011-2012

Emergency Contact/Emergency Pickup Information

By signing this form you are agreeing to pick up your child in a timely manner when notified by us that this is necessary.

Child's Full Name_____

TWO EMERGENCY CONTACTS WHO ARE AUTHORIZED TO PICK UP MY CHILD IN THE EVENT OF AN EMERGENCY AND/OR WHEN PARENTS CANNOT BE REACHED

Emergency contacts must be in the immediate area!

(**These two are not child's parents**)

1. Name _____
   Relationship to Child_____
   Address _____
   Phone #1 _____
   Cell Phone #_____

2. Name_____
   Relationship to Child_____
   Address_____
   Phone #1 _____
   Cell Phone#_____

Child's Physician_____ **Phone#**_____

All Persons Authorized to Deliver/Pick-Up Children

Please provide the following information about the persons who will be transporting your child to and from the preschool. (**Include the names of child's parents/guardians**.) For your child's safety, he/she will be released ONLY to the persons listed on this form. Any other arrangements must be authorized by the parent/guardian *in writing*.*

Name	Relationship to Child	Phone Number	Alt. Phone #
Parent:			
Parent:			
Other:			

*In case of an emergency where you will have someone other than those persons listed above pick up your child, please call the preschool office at (703) 938-6187 for authorization.

_____ _____

Parent/Guardian Signature Date

PLEASE FILL OUT THE BACK OF THIS FORM

Fairfax Hospital Association
Authorization for Emergency treatment.

I,_____, hereby authorize
(parent or guardian)
Any physician, member of the Department of Emergency Medicine of Inova Fairfax Hospital, Reston Hospital or Fairfax Access and/ or any member of the Medical Staffs of the above mentioned hospitals requested by the Department of Emergency Medicine Physicians, to render any medical treatment, which in his/her judgment May be deemed necessary in the care of (child)_____

Child's Allergies _____

Child's Dr._____Phone #_____

Medicines child takes regularly_____

Last tetanus shot_____

Outstanding Medical History (Diabetes, heart disease etc.)_____

Insurance Information

Insurance Company_____

Identification/Policy #_____

Subscriber's name_____

Place of Employment_____

Subscriber's telephone #_____

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 or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, 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: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I
To be completed by a physician, 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 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

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ❑ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

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:** _____