Afternoon Pick-Up Registration Form
2016/2017

In order to relieve traffic congestion and make evening pick up more convenient for parents of students in K4-8th grade, we provide an Afternoon Pick-Up service from 3:30-3:45pm and again from 5:15-6:15pm. Students participating in Afternoon Pick-Up remain indoors at their dismissal time. Parents drive into the circle in front of the School building where a Merritt staff member identifies the automobile by its licesne plate and uses a walkie-talkie to call for the child(ren) to come down to the waiting car.

This form must be completed and turned into the Front Office prior to participating in afternoon Pick-Up.

Please Print

Parent/Guardian Name _____
(First) (Last)

Student(s) Name_____
(First) (Last) (Grade)

_____
(First) (Last) (Grade)

_____
(First) (Last) (Grade)

License Plates: State Plate Number

_____

_____

_____

_____

I, _____, give permission for the registered cards identified above to pick up my child(ren) through Afternoon Pick-Up at ☐3:30-3:45pm or ☐5:15-6:15pm.

Parent/Guardian Signature:_____Date:_____

Afternoon Pick-Up will begin on Tuesday, August 30th, 2016 for those who have registered by August 23rd. After that date, please allow 24 hours for your registration to be processed before participating in Afternoon Pick-Up.

If you have any questions about this service, please contact Mary DeJager, Assistant to the Principal at maryd@merrittacademy.org or Linda Potts, Principal, at lindap@merrittacademy.org.

Emergency Contact Form
2016 – 2017

Student Information			
Child's Name:			
	Last	***First***	***Nickname***

Home Address:				
	Street Address	***City***	***State***	***Zip***

2016-2017 Grade:	**Date of Birth**	

Parent/Guardian Information			
Mother/Guardian		**Father/Guardian**	
Last Name	***First Name***	***Last Name***	***First Name***

Home Address:		**Home Address:**	
Email Address:		**Email Address:**	
Home Phone:		**Home Phone:**	
Mobile Phone:		**Mobile Phone:**	
	☐ **Please check here to receive text alerts for school closings on your cell phone.**		☐ **Please check here to receive text alerts for school closings on your cell phone.**
Employer:		**Employer:**	
Work Address:		**Work Address:**	
Work Phone:		**Work Phone:**	

Health Information			
Physician Name:		**Physician Phone #:**	
Allergies: **(food, drugs, etc)**		**Medical Conditions:** **(seizures, blood disorder, etc.)**	
Action to take:		**Action to take:**	

Updated 7/14/2016

Student's Name:_____________________________
Last First

Please list TWO additional emergency contacts within a 10 mile radius of Merritt Academy other than parent/guardian who can be called in case of an emergency situation.

Name		Relationship to child
Last Name	*First Name*	

Address:		Home Phone	
		Work Phone	
		Mobile Phone	

Name		Relationship to child
Last Name	*First Name*	

Address:		Home Phone	
		Work Phone	
		Mobile Phone	

Who is authorized to pick up this child?

If either parent is NOT authorized to pick up this child Merritt Academy must have custodial papers on file stating this.

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Name		Relationship to child
Last Name	*First Name*	

Parent Handbook Agreement
2016-2017

I grant permission for my child to participate in Merritt Academy field trips and in visits to Sunrise Senior Living Communities and other senior living communities. I understand that I will be notified in advance of the destination and time of all field trips and that I have the option of keeping my child at home if I choose not to allow his or her participation. I understand that field trips may be cancelled due to weather, safety, transportation or shortage of chaperones.

I agree to release, waive, indemnify and hold harmless Merritt Academy and its owner, The J127 Education Foundation, and their respective officers, director, employees, volunteers and agents (collectively "Merritt") from all claims, demands, suits, causes of action, or judgments which my child or I ever had, now have, or may have in the future or which my child's family, heirs, executors, administrators, or assigns may have, or claim to have against Merritt, arising out of or in any way connected with my child's attendance at Merritt Academy, for all personal injuries, property damages (including theft), or claims for wrongful death, caused by the acts, omissions or ordinary negligence of Merritt.

I agree to inform the school within 10 business days of any changes to the following, so that my child's Emergency Care Information may be updated: marital or occupational status, address and/or phone numbers, email address, allergies (if any), child's doctor information.

I agree to pick up my child within one hour should the school inform me that my child is ill. I understand that he/she should remain at home for 24 hours after symptoms clear before being allowed to return to school if fever, diarrhea or vomiting is present, or 24 hours after being placed on antibiotics.

I authorize Merritt Academy to obtain immediate emergency care in the event I cannot be reached immediately.

I authorize Merritt Academy to call my child's Emergency Contacts in the event that the child has not been picked up by the time school closes and we are unable to reach parent(s) via phone; or in the event of an emergency if parent(s) is unable to be reached by phone, or parent(s) are unable to get to the school within 1 hour.

I grant permission for Merritt Academy to use photographs or videos of my child, both print and electronic, in promotional materials, unless otherwise noted, without compensation.

I agree to notify the school within 24 hours if my child or anyone in our household develops any reportable communicable disease.

I hereby pledge to join the faculty in supporting and upholding the Code of Courtesy in word and deed.

I agree to adhere to Merritt Academy's Parking Lot Rules and exercise courtesy with other drivers in the school parking lot. I agree not to participate in behavior that sets a poor example to students as part of upholding the Code of Courtesy.

I agree to have my child participate in counseling and guidance provided by the school counselor including: lunch bunches, second steps lessons and 1-2 counseling sessions designed to promote a productive learning environment.

I have read the current edition of the Merritt Academy Parent Handbook posted on the Administration, Principal and teacher Shutterfly pages and accept and agree to all policies stated within.

All Merritt Academy parents are members of the Merritt Academy Parent-Teacher Organization (PTO). I give permission for the Merritt Academy PTO to add me as a member to their Shutterfly shared site.

By typing your name below, you agree that this is valid as your signature.

Parent Signature: _____ Date: _____ ___

Child's Name: _____ Child's Grade_____

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: _____/_____/_____

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.)

Certification of Immunization 10/2010

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:** _____