Pre-K 4

Enrollment

Packet

Amelia Academy

P.O. Box 106 • 8741 North Five Forks Road • Amelia, Virginia 23002 • (804) 561-2270 • Fax: (804) 561-4934 • www.AmeliaAcademy.com

Pre-school Application must be accompanied with a deposit of $100, which will be deducted from the tuition. See the Tuition and Fee Schedule for additional information.

☐ Three-day Program (Mon/Wed/Fri only; No make-up days) ☐ Five-day Program

Child	Nickname	Date of Birth	Sex

Address	Home Phone

Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed

Previous Child Day Care Programs and Schools Attended

If Child Attends this Center and Another School/Program, Give Name of School/Program	Grade

PARENT(S)/GUARDIAN(S)

Father	Place Employed	Business Phone

Home Address	Home/Cell Phone

Mother	Place Employed	Business Phone

Home Address	Home/Cell Phone

Person(s) or Agency Having Legal Custody of Child

Home Address	Home/Cell Phone

Business Address	Business Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency

Child's Physician	Phone

Two People To Contact if Parent(s) Cannot Be Reached	Address	Phone
1.	1.	1.
2.	2.	2.

Person(s) Authorized To Pick Up Child

Person(s) NOT Authorized To Pick Up Child*

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

Amelia Academy I heard about the Amelia Academy Preschool program from: _____

AGREEMENTS

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

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

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

SIGNATURES

_____ _____ _____

Parent(s) or Guardian(s) *E-mail Address* *Date*

_____ _____

Administrator of Center *Date*

Date Child Entered Care: _____ Date Left Care: _____

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

OFFICE USE ONLY
IDENTITY VERIFICATION

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

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

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

_____

Date

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

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

Amelia Academy

MONTHLY PAYMENT SCHEDULE

2020-2021

K - 12 Annual Re-Enrollment Fee (per child)

Paid before or on June 1, 2020	**$300**
Paid after June 1 but before August 3, 2020	**$375**
Paid on or after August 3, 2020	**$450**

Annual Fees (per child)

Prekindergarten	**$50**
K-12	**$400**

Annual Transportation Fee

PreK-12 (per family)	**$650**

PAY TUITION AND ALL FEES BY JUNE 1, 2020, FOR A $300 TUITION DISCOUNT

	TUITION IN FULL		10 Month Plan (August - May) FINANCE CHARGE $115/Month	10 Month Plan (August - May) MONTHLY PAYMENT		12 Month Plan (June - May) FINANCE CHARGE $115/Month	12 Month Plan (June - May) MONTHLY PAYMENT
PRE-SCHOOL (5 DAYS)							
First Child	$ 5,100.00			$ 510.00			$ 425.00
Second Child	$ 5,000.00			$ 500.00			$ 416.67
Third Child	$ 4,900.00			$ 490.00			$ 408.33
Fourth Child	No Charge						
PRE-SCHOOL (3 DAYS)	$ 3,990.00			$ 399.00			$ 332.50
KINDERGARTEN							
First Child	$ 6,445.00		$ 1,150.00	$ 759.50		$ 1,380.00	$ 652.08
Second Child	$ 6,345.00		$ 1,150.00	$ 749.50		$ 1,380.00	$ 643.75
Third Child	$ 6,245.00		$ 1,150.00	$ 739.50		$ 1,380.00	$ 635.42
Fourth Child	No Charge						
GRADES 1 - 8							
First Child	$ 7,350.00		$ 1,150.00	$ 850.00		$ 1,380.00	$ 727.50
Second Child	$ 7,070.00		$ 1,150.00	$ 822.00		$ 1,380.00	$ 704.17
Third Child	$ 6,620.00		$ 1,150.00	$ 777.00		$ 1,380.00	$ 666.67
Fourth Child	No Charge						
GRADES 9-12							
First Child	$ 7,450.00		$ 1,150.00	$ 860.00		$ 1,380.00	$ 735.83
Second Child	$ 7,170.00		$ 1,150.00	$ 832.00		$ 1,380.00	$ 712.50
Third Child	$ 6,720.00		$ 1,150.00	$ 787.00		$ 1,380.00	$ 675.00
Fourth Child	No Charge						

Tuition Payment Plans

1. Pay in full by August 31, 2020
2. There will by a $30 late fee per month on late payments
3. Ten (Aug - May) or 12 (June - May) monthly installments with finance charge (see monthly Payment Schedule)
4. Personal loan through bank of your choice -- the interest rate will depend on your collateral

TUITION CONTRACTS ARE TO BE SIGNED BY BOTH PARENTS IN THE OFFICE.

Amelia Academy is an approved facility to train veterans and eligible persons through the Post-9/11 GI Bill. Our facility is compliant with the VA Delayed Payment Compliance Addendum. Please refer to the Student Handbook.

AMELIA EDUCATIONAL FOUNDATION, T/A AMELIA ACADEMY (AEF)
STUDENT ENROLLMENT CONTRACT 2020-21

Enrollment Contract: Tuition and appropriate enrollment fee must accompany this contract. (Do not deduct enrollment fee from tuition.)

Tuition Schedules for 2020-2021 are as follows:

- Tuition in advance through lump-sum payment:

Pre-School	$5,100.00	Grades 1-8	$7,350.00
Kindergarten	$6,445.00	Grades 9-12	$7,450.00

- Tuition financed through AEF (available in 10 monthly installments August through May or in 12 monthly installments June through May) with $115 finance charge added monthly.

The undersigned promise to pay for student(s) in grades P/K – 12 in the amount of $_____. This amount will be: (Please select one plan)

____ Paid by August 31, 2020 in one lump sum payment.
____Financed through AEF in ____ installments which includes the cost of tuition and a finance charge. Monthly payments in the amount of $_____ are to be made by the 1st of each month beginning _____, and the last payment to be made May 1, 2021. A late fee of $30.00 per month will be added on any late payment.

Priority of placement in a particular grade shall be granted based on the date this contract is signed by all parties.

In consideration of the provisions herein, AEF agrees to provide educational opportunities for the following student(s) for the 2020-2021 school year:

Student's Name	**Birth Date**	**2020-2021 Grade**
_____	_____	_____

The undersigned has read and agrees to the following:
Tuition for students who are dismissed for disciplinary reasons will not be refunded.
Tuition for students who withdraw voluntarily will be proportionately reimbursed. Fees, book sales, and book rentals are not refundable. **Any installment payment plan that is 30 days overdue will result in the student not being allowed to return until payments are brought up-to-date.** AEF reserves the right to hold all transcripts and /or diplomas until all financial obligations are paid in full. Tuition shall still be due, and AEF shall not be liable where AEF's inability to perform/school closure is caused by circumstances beyond its control, including, but not limited to, Acts of God, natural disasters, or federal, state or local governmental action not attributable to negligence by AEF.

If AEF brings suit on this contract and a court grants AEF judgment, **parent/guardian specifically agrees to pay as a penalty, in addition to any late fees stated above, a 21% rate of interest per annum on any delinquent amounts, starting from the date said payment was originally due. Parent/guardian further agrees to pay any of AEF's reasonable attorney fees and court costs, along with a 21% rate of interest per annum on the total judgment amount, all from the entry date of said judgment.**

Both parents must sign this agreement in the office. If parents do not have custody, then this agreement must be signed by the person or persons having legal custody of the above named child(ren) and must attach a certified copy of a current court order.

Parent/guardian grants permission for above child's pictures to appear in AEF promotional material, including, but not limited to, social media and the Internet. If you do not wish child's picture(s) to so appear, please notify the office in writing within 5 days of signing this contract.

X _____
Parent's/Guardian's Signature Social Security No. Date

_____
Notary or Amelia Academy Office Personnel Date

X _____
Parent's/Guardian's Signature Social Security No. Date

_____
Notary or Amelia Academy Office Personnel Date

_____
Head of School's Signature Date

Revised 4/28/2020

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: Amelia Academy Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____ Phone: ___-___-_____ Work or Cell: ___-___-_____

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

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

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.):

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

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

Please provide the following information:

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

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

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

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

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

Signature of Interpreter: _____ Date: ____/____/_____

MCH 213 G revised 10/2010

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official. See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |___|___|___|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

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

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

Student's Name:_____ Date of Birth: [___ [___ [___]

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): [___[___[___].

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

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

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

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)). **(requirements are subject to change.)**

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth

Student's Name: _____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: _____ mm

Physical Examination

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

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

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

Blood Lead: _____ Hct/Hgb _____

Developmental Screen

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

Hearing Screen

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

	1000	2000	4000
R			
L			

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

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

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ **Hearing aid or other assistive device**

Vision Screen

☐ With Corrective Lenses (check if yes)

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

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

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

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

Summary of Findings (check one):

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

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

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

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

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

___ **Restricted Activity** Specify: _____

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

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

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

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

Name : _____ **Signature:** _____ Date: ____/____/_____

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

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