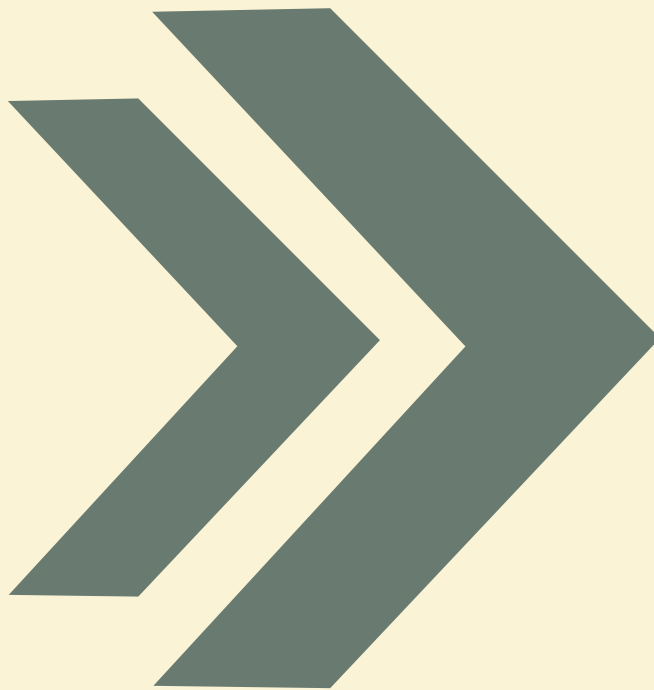


**NSU Child
Development Lab
2023 - 2024**



*We're Moving
Forward!*

**Registration
Packet**

Norfolk State University
Child Development Lab
Child Registration Form

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			
Name of Child Day Care Program Currently Attending			Grade or Class Level

PARENT(S)/GUARDIAN(S)

Person 1	Place Employed	Work Phone
Home Address		Home Phone
Person 2	Place Employed	Work Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Actions to Take in an Emergency		
Child's Physician		Phone
Emergency Contact (Required: 2)	Address	Phone
1.	1.	1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) <u>NOT</u> Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent/person 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 daycare center (i) shall not be denied the opportunity to participate in any of the student's school or daycare activities in which such participation is supported or encouraged by the policies of the school or daycare center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or daycare activities.

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 emergency 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) _____

Date _____

Program Director _____

First Date of Attendance _____ Last Date of Attendance _____

** 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):

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 § 22.1-289.049 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..

Norfolk State University
Child Development Lab
Child and Family History

Name of Child _____ Date of Birth _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Brothers and/or Sisters of Child:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Other Members of Household (Include Relationship and Age)

Please, provide the family's ethnic background _____

Home language _____

Does the child have a room alone or a shared room? Alone Share

Has the child had group play experience? Yes No If yes, where _____

Does the child have neighborhood playmates? Yes No

Developmental History of Child

Age at which child – Walked _____ Began Toilet Training _____ Word
child uses for – Urination _____ Bowel Movement _____ Usual time
for bowel movement _____

Does the child dress self? _____

Is the child right or left-handed? _____

What time does the child usually eat: breakfast _____ lunch _____ dinner _____

Is the family vegetarian? _____

Other dietary restrictions _____

What time does the child usually go to bed at night? _____ Awaken? _____

Indoor play restrictions _____

Outdoor play restrictions _____

Does child play with water? _____

Does the child have any special fears that you are aware of?

What method do you use to control your child's behavior in your home?

What is the child's usual reaction? _____

How would you describe your child's personality? _____

Health History

1. Does the child have any physical condition that we should be aware of?

2. Is the child allergic to any specific foods, medication, or any other? Yes No

If yes, please indicate _____

3. Any previous illnesses? Yes No

4. Is the child under the care of a doctor? Yes No

If yes, for what reason?

5. Does this child require special attention, medication, or routines that may have to be taken into consideration in planning for his/her daily activities? Yes No

If yes, please explain _____

List the names of the person(s) who will be authorized to access your child's information.

**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: _____
 Student's Date of Birth: ____/____/____ Last First Middle
 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				
	1	2	3	4	5
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)					
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)					
*Tdap booster (6 th grade entry)					
*Poliomyelitis (IPV, OPV)					
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age					
*Pneumococcal (PCV conjugate) *only for children <60 months of age					
Measles, Mumps, Rubella (MMR vaccine)					
*Measles (Rubeola)			Serological Confirmation of Measles Immunity:		
*Rubella			Serological Confirmation of Rubella Immunity:		
*Mumps					
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used					
*Varicella Vaccine			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine					
Meningococcal Vaccine					
Human Papillomavirus Vaccine					
Other					
Other					

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 _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>HEENT</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Neurological</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Skin</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Abdomen</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Genital</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Extremities</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Urinary</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3		1	2	3		1	2	3																																						
	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
TB Screening: <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified																																																		
Test for TB Infection: TST IGRA Date: _____ TST Reading _____mm TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																		
EPSDT Screens <u>Required</u> for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

Developmental Screen	Assessed for:	Assessment Method:	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Gross Motor Skills				

Hearing Screen	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)			
	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L
		20/	20/	20/
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen				

Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
----------------------	--

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____ _____ _____	
	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	___ Restricted Activity Specify: _____	
	___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> 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) <input type="checkbox"/> 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: _____

Norfolk State University
Child Development Lab
Child Release Form

Our Licensing standards require complete information on both parents. Parents who are separated, divorced, and any single parent must provide appropriate legal guardianship documentation if only one parent is the sole guardian of the child. If the parent does not give the other parent's information, i.e., court documents for sole guardianship, our school does not have the authority to withhold the child from the other parent when they come to pick up the child from the school.

I have read the above statement and fully understand and agree with the program's policy that it is not accountable for releasing my child to their parent without the legal documentation of sole guardianship.

Child's Name _____

Mother's Name _____

Address _____

Phone Number _____

Father's Name _____

Address _____

Phone Number _____

Guardian's Name _____

Address _____

Phone Number _____

Parent/Guardian Signature

Date

Norfolk State University
Child Development Lab
Confidentiality Policy

Our program stresses the importance of protecting the rights and privacy of children, families, and staff. The practice of maintaining the confidentiality of verbal information and written records is a basic policy of our program. It is program policy that staff and participating students should not repeat or share private information they received from the children.

It is also the program's policy that families must not share or post other children's information or photos on social media without authorization from the school or children's parents.

All children's information is kept confidential and locked. Information is accessible to authorized program staff only. The preschool program will only release the child's information to those individuals, agencies, schools, or facilities authorized by the child's parent/guardian.

I give authorization, to share and access my child's information, to the names below:

1. _____
2. _____
3. _____
4. _____

I have read, understood, and will comply with the NSU Child Development Lab's confidentiality policy.

Child's Name _____

Parent's Signature _____ **Date** _____

***All blanks must be completed. Write N/A or None where applicable**

**Norfolk State University
Child Development Lab
Emergency Form**

1. Child's Name (First)_____ (Middle)_____ (Last)_____
Nick Name _____ Age _____ Birth Date _____
Home Address _____ City _____ Zip _____
Home Phone _____
2. Mother's (Guardian) Name _____
Address (If different from above) _____
Place of Employment _____
Business Telephone _____ Cell Phone _____
E-mail address _____
3. Father's (Guardian) Name _____
Address (If different from above) _____
Place of Employment _____
Business Telephone _____ Cell Phone _____
E-mail address _____
4. Physician's Name _____ Telephone _____
Emergency Hospital Preference _____

***All blanks must be completed. Write N/A or None where applicable**

5. Emergency Contacts

Please provide COMPLETE information for three Emergency Contacts.

Two contacts must have a different address than the home address listed above.

1. Name _____

Address _____

Home Telephone _____ Cell Phone _____

Work Phone _____

2. Name _____

Address _____

Home Telephone _____ Cell Phone _____

Work Phone _____

3. Name _____

Address _____

Home Telephone _____ Cell Phone _____

Work Phone _____

6. List persons **AUTHORIZED** to pick up child:

(1) _____

(2) _____

(3) _____

(4) _____

Any additional information the school needs to know (allergies, dietary needs, medical conditions, etc)

Parent/Guardian's Signature

Date

Norfolk State University
Child Development Lab
Infection Control and Sick Policy

Children will inevitably get sick, no matter where they are. As children begin to have contact with the world outside that of their own families, they encounter viruses and bacteria that are foreign to their bodies. This is the way they build immunities. We cannot, nor would we want to, shield a child completely from the outside world. If we did, the natural immunities a child gains through contact with others would not develop and a simple cold could become a serious illness. We do, however, want to protect a child from an unusually high exposure to germs all at once.

In a childcare setting, children meet groups of other children outside their families. It is in this situation that the illness of one child can spread rapidly through the group to other children and staff members if stringent measures to prevent this spread are not taken.

For this reason, the staff at the center will take constant precautions to prevent the spread of disease. Many common childhood diseases are contagious. They are caused by germs which may be spread in several ways. Intestinal tract infections are spread through stools. Respiratory tract infections are spread through direct contact. Careful hand washing by staff and children can eliminate approximately 75 percent of the risk of spreading these illnesses. Other precautions include separating sick children from those who are well, taking extra precautions with toilet training children, and working to maintain sanitary conditions throughout the center.

You, the parents, can help us in our effort to keep your children healthy. We ask for your cooperation in the following ways:

1. If your child or any family member has been exposed to any of the diseases listed on the accompanying list, we ask that you notify us of the exposure as soon as possible.
2. If your child shows any of the following symptoms you will be called and asked to pick up your child immediately. Please help us protect the other children by responding promptly. If your child has any of the following symptoms at home, we ask that you keep him/her out of school until the symptoms are gone or note from the physician stating that it is safe for the child to return to school.
3. For those children who have some of the following symptoms (runny nose, coughing, or difficulty breathing) related to their allergy or Asthma problems, the parent must provide the statement from the physician stating that the child's symptom is related to the allergy or asthma, and it is not contagious.
4. Please be alert to a child who may have a cold and start to have more major symptoms and ensure he/she is seen by a doctor.
5. Children must be fever-free for 24 hours before returning to school.

The symptoms include:

- o fever greater than 100°F. or 37.7°C
- o constant severe coughing
- o high-pitched croupy or whooping sounds after coughing
- o constant runny nose
- o difficult or rapid breathing
- o yellowish skin or eyes
- o pinkeye – tears, redness of eyelid lining, followed by swelling and discharge of pus. o unusual spots or rashes
- o sore throat or trouble swallowing
- o infected skin patches
- o crusty, bright yellow, dry, or gummy areas of skin – possibly accompanied by fever. o unusually dark, tea-colored urine – especially with a fever
- o grey or white stool
- o headache and stiff neck
- o vomiting
- o severe itching of the body or scalp or scratching of the scalp.

Chicken Pox – cannot return until all lesions have been crusted.

Mumps – cannot return until nine days after onset of swelling of parotid glands.

Measles – cannot return until six days after the onset of the rash.

Rubella – cannot return until six days after the onset of the rash.

Conjunctivitis (pink eye) – stay home until 24 hours after the start of antibiotic treatment and until there is no discharge from the eyes.

Strep throat – cannot return until fever-free and have taken antibiotics for at least 24 hours.

A child cannot return to school until approved by the health care official for the following symptoms:

- Tuberculosis
- Haemophilus influenza type b (HIB)/meningococcal infection
- Hepatitis A virus

If any of the above symptoms are present or if a child appears cranky, less active than usual, weak, cries more than usual, or just seems generally unwell at home, we ask that you keep your child at home until the symptoms are gone or notification from the doctor it is safe to return to school.

When your child comes to school when he/she is not normal self it is difficult for the child to participate in class activities and more likely you will receive a call from the school to pick up your child. Please, keep your child at home at least 24 hours after the onset of symptoms or until 24 hours after the treatment has been initiated with the physician's note stating that symptoms are clear before your child returns to school.

Handwashing Policy

1. Adults & children must wash their hands at the sink by the door.
2. Adults must supervise proper hand-washing procedures. Please regulate the water temperature.
3. Children are not left unattended at the sink.
4. Adults must wash their hands even if entering the office for administrative purposes or dropping off supplies for their child's cubby.
5. Children are not permitted to enter the cubby area before washing their hands.
6. Children must wash their hands at the sink by the door and not in the bathroom.
7. **If you walk beyond the stop sign, you must wash your hands**

Norfolk State University
Child Development Lab
Parent Agreement for Infection Control and Sick Policy

By signing below, I acknowledge that I have received, fully read, and understood the attached Infection Control and Sick Policy. I agree to abide by them for the protection of my child, as well as the other children, and staff members at NSU Child Development Lab. I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with staff.

Child's Name: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian

Date

Norfolk State University
Child Development Lab
Late Pick-Up Policy

There is a late pick-up charge of \$2.00 per minute during the first five minutes past your scheduled dismissal time. The late fee increases to \$5.00 per minute after that. Payment is due within three days.

Families will be charged a late pick-up fee if a child is not picked up by the end of his/her program. If a child is not picked up by the end of his/her program, and we are unable to contact the parents or someone on your emergency list, we will alert the police and the Virginia Department of Social Services. Non-compliance with our Late Pick-Up Policy will result in the following: The Program Director reserves the right, based on the frequency of situations such as picking a child up late (more than three times), to decide to terminate enrollment services. In the event this should occur, the Program will give the family a two-week notice in advance to allow them time to find alternative early childhood services (extreme situations, however, will result in immediate termination of enrollment).

- | | |
|--|----------------------|
| 1. I have read the late pick-up policy. | Initial _____ |
| 2. I understand the late pick-up policy. | Initial _____ |
| 3. I will abide by the late pick-up policy of the Norfolk State University Child Development Lab. | Initial _____ |

Print Child's Name

Parent/Guardian Signature

Date

Norfolk State University
Child Development Lab
Program Decision on the Administration of Medication

NSU Child Development Lab has made the following decision regarding the administration of medication: **Authorized staff WILL ONLY administer prescription medications.** The Child Development Lab will administer prescription medication by all routes covered in the MAT course (oral, topical, eye, ear, patches, and inhaled, medications and epinephrine via an auto-injector device).

The Child Development Lab will administer medication under VDSS child day program regulations about the administration of medication in a child day program. Only a staff member who has completed the appropriate training or has appropriate licensure, and is listed as a medication administrator in the Program's Decision Regarding Medication Plan will be permitted to administer medication in the program.

Forms and Documentation Related to Medication Administration

Medication Consent Form: The program will accept permission and instructions to administer medication on the VDSS form Written Medication Consent Form.

Handling Storage and Disposal of Medication

All medication will be properly labeled with the child's first and last name and be accompanied by the necessary parent permission and health care provider instructions under VDSS regulations **before** it will be accepted by the parent or parent representative. All medication will be kept in its original labeled container. Medication will be kept in a locked place using a safe locking method that prevents access by children.

Medication Errors

If a medication error occurs in the program, we will notify the child's parent immediately. We will maintain the confidentiality of all children involved.

Confidentiality Statement

Information about any child in the program 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 any child in my program will be given to the local Department of Social Services if the child receives a daycare subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

ADA Statement for Programs

The program will comply with the provisions of the Americans with Disabilities Act. If any child enrolled in my program now or in the future is identified as having a disability covered under the Americans with Disabilities Act, we will assess the ability of the program to meet the needs of the child. If the program can meet the needs of the child without making a fundamental alteration to the program, the child will not be excluded from the program.

Provider Statement

We understand that it is our responsibility to follow the PROGRAM’S DECISION REGARDING MEDICATION plan and all health and infection control regulations applicable to child day programs. We will verify and document the credentials for all new staff certified to administer medication before the staff is allowed to administer medication to any child in the program.

The PROGRAM’S DECISION REGARDING MEDICATION plan will be made available to parents at enrollment, whenever changes are made, and upon request.

The provider and the parent of each enrolled child must sign below.

A copy of this form must be maintained in each child’s file.

Facility Name: NSU Child Development Lab

Provider’s (staff) Name (print): _____

Provider’s (staff) Signature: _____ **Date:** _____

Parent or Guardian’s Signature: _____ **Date:** _____

Norfolk State University
Child Development Lab
Medication Authorization Form
For Prescription and Non-Prescription Medications

(8VAC20-780-510)

Section A must be completed by the parent/guardian for **ALL** medication authorizations which shall expire or be renewed after 10 work days.

Section A and Section B must be completed for any **long-term prescription and over-the-counter medication which** may be allowed with written authorization from the child's physician and parent.

Section A: To be completed by parent/guardian

Medication authorization for: _____
(child's name)

_____ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication			
Dosage			
Administration (times)			
Special instructions (if any)			

This authorization is effective from: _____ until: _____
(Start date) (End date)

Parent or Guardian's Signature: _____ Date: _____

Section B: to be completed by the child's physician:

I, _____ certify that it is medically necessary for the
(name of physician)
medication(s) listed below to be administered to: _____ for a
(child's name)
duration that exceeds 10 work days.

Medication			
Dosage			
Administration (times)			
Special Instructions (if any)			

This authorization is effective from: _____ until: _____
(Start Date) **(End Date)**

Physician's Signature: _____

Physicians Phone: _____ Date: _____

Norfolk State University
Child Development Lab
No Hit Zone Policy



PURPOSE

The purpose of this campaign is to establish an environment of care and health that excludes hitting of any kind.

- The No Hit Zone campaign educates the public about the risks associated with hitting a child as punishment.
- The No Hit Zone campaign provides public notice that hitting is not acceptable in the “zone” designated as a No Hit Zone.
- No Hit Zone implementation **changes the conversation** in a constructive way for all.

VISION

A community where healthy child development is supported through safe and effective interpersonal interactions that do not involve hitting.

No Hit Zone takes a stand on physical punishment and interpersonal violence.

Physical abuse is the use of physical force, such as hitting, kicking, shaking, burning, or other shows of force against a child.

Punishment – a penalty inflicted for an offense

- Punishment is a penalty. Physical punishment is penalizing a person usually by hitting or striking the body.

No Hit Zone Rules

An environment in which:

- No adult shall hit another adult
- No adult shall hit a child
- No child shall hit an adult
- No child shall hit another child

Norfolk State University
Child Development Lab
Parent Acknowledgement of No Hit Zone Policy

By signing below, I acknowledge that I have received, fully read, and understood the attached **No Hit Zone Policy**.

I understand that the NSU Preschool Academy is a No Hit Zone Site (this includes the classrooms, hallways, bathrooms, and parking lot).

I declare that I have reviewed this policy and will do my best to support a **No Hit Zone** environment for my child at the NSU Child Development Lab and home.

I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with staff.

Child's Name: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian

Date

Norfolk State University
Child Development Lab
Nutrition Policy

To provide the best possible nutrition for the children in our facility, we have adopted the policies as listed below. As advised by the Centers for Disease Control, children are provided with an environment that encourages and teaches healthy food and drink habits.

Fruits and Vegetables

- ✓ We offer fruit to children at least 2 times a day.
- ✓ We only offer fruit canned in its own juice (no syrups), fresh, or frozen.
- ✓ We offer vegetables to children at least 2 times a day.
- ✓ We only offer vegetables steamed, boiled, roasted, or lightly stir-fried with little added fat.

Meats, Fats, and Grains

- ✓ We never offer fried or pre-fried (frozen and breaded) meats (chicken nuggets) or fish (fish sticks).
- ✓ We never offer fried or pre-fried potatoes (French fries, tater tots, hash browns). ✓ We offer beans or lean meats at least once a day.
- ✓ We offer high-fiber, whole-grain foods at least 2X a day.

Added Sugar and Salt

- ✓ We follow the American Heart Association's recommendations for daily added sugar and salt servings. For children over the age of 2:
 - o no more than 25 grams of added sugar daily,
 - o no more than 2,300 grams of salt
- ✓ We make an effort to limit the serving of foods with added sugars and salts.

Beverages

- ✓ We make drinking water a priority for children. It is freely available so children can serve themselves both inside and outdoors.
- ✓ We rarely offer sweetened drinks other than 100% juice.
- ✓ We offer no more than one serving of 100% fruit or vegetable juice per day (1/2 cup for breakfast or 1/4 cup for lunch or supper)
- ✓ We serve only 1% of skim milk to children age 2 or older.
- ✓ We do not have soda or other vending machines on site.

Menus and Variety

- ✓ We have a 4-week cycle menu that allows for seasonal changes.
- ✓ Our menus include healthy items from a variety of cultures.
- ✓ Our menus include a combination of new and familiar foods.

Feeding Practices

- ✓ Our staff helps children determine if they are full before removing their plates.
- ✓ Our staff helps children determine if they are still hungry before serving additional food.

- ✓ Our staff gently and positively encourage children to try a new or less favorite food.
- ✓ We do not use food to encourage positive behavior.

Foods Offered Outside of Regular Meals and Snacks

- ✓ We provide and enforce written guidelines for healthier food brought in and served for holidays and celebrations.
- ✓ Celebrations are inclusive, respectful of everyone’s beliefs, and aligned with our policies. For
 - o Instead of food items, we offer students an opportunity to choose an item from our birthday menu as a way to celebrate their special day.
- ✓ We celebrate holidays with mostly healthy foods or non-food treats.
- ✓ Our fundraising efforts consist of selling minimal non-food items.

Supporting Healthy Eating

- ✓ Our staff join children at the table for meal times.
- ✓ We always serve meals family style.
- ✓ Our staff always consume the same food and drink as the children.
- ✓ Our staff never eat unhealthy foods in front of the children.
- ✓ Posters, pictures, and books are displayed to provide visible support for good nutrition in classrooms and common areas
- ✓ Our staff often talk informally with the children about trying and enjoying healthy foods.

Nutrition Education for Staff, Children, and Parents

- ✓ We provide teacher-directed nutrition education to the children, through a standardized curriculum, 1X per week or more.

Staff Training

- o Information on the nutrition policy is included in the staff orientation.
- o Training opportunities for staff on nutrition (other than food safety and food program guidelines) are offered at least once a year.

Parent Communication

- o We communicate regularly with parents and provide information and advice on child nutrition, obesity prevention, healthy food and drink habits, and healthy recipes to try at home. For example newsletters, orientation days, information sessions, and informal discussions.
- o We will offer nutrition education to parents 2X per year or more.

Adapted from both “Child Care Nutrition and Physical Activity Policies” by the NAP SACC Program, Center for Health Promotion and Disease Prevention, The University of North Caroline, Chapel Hill, NC, May 2007; and, “Best Practices for Healthy Eating” by the Nemours Foundation, 2016.

Norfolk State University
Child Development Lab
Parent Agreement for Nutrition Policy

By signing below, I acknowledge that I have received, fully read, and understood the attached **Nutrition Policy**.

I declare that I have reviewed this policy and will do my best to support a healthy environment for my child at the NSU Child Development Lab and home.

I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with staff.

Child's Name: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian

Date

Norfolk State University
Child Development Lab
Participant Authorization/Permission Form

Child's Name: _____

Photo/Video Release Authorization

I give my permission for my child's photograph/video to be taken during any school event or activity to be used for internal publicity, in the Commonwealth of Virginia and/or throughout the United States. These photographs, videos, and sound bytes may be used for program brochures, media productions, advertisements, photo albums, or news articles.

Please initial: _____

Field Trip Permission and Transportation Authorization

I give my permission for my child to participate in field trip activities (walking, and/or bus). I understand that activity calendars will notify me of trips that are scheduled and that it is my responsibility to obtain a calendar and make sure my child reaches the school by the stated time of departure. I am aware that I will be informed of upcoming field trips and be allowed to accompany the group. I understand that my child will be transported on Norfolk State University vehicles for scheduled field trip activities.

Please initial: _____

Sunscreen/Insect Repellent Permission

I am aware that the school staff will monitor the application of sunscreen and insect repellent by participants in the School Program. I am aware that I must provide the product and that I must complete a Written Medical Consent Form for topical creams. I permit NSU Child Development Lab representatives to apply the sunscreen or insect repellent that I provide for my child.

Please initial: _____

Movie Viewing Consent

I permit my child to view movies according to their age G & PG for ages 12 and under.

Please initial: _____

Assessments Permission

I am aware that my child will be assessed throughout the school year by staff and school representatives. Assessments may include work samples, developmental checklists, ongoing observations, and other activities.

Please initial: _____

Emergency Medical Care Permission

I give my permission for the program staff to take the necessary steps to obtain medical and dental emergency care if warranted. These steps may include but are not limited to the following: (1) Attempt to contact the parent(s). (2) Attempt to contact the physician. (3) Attempt to contact the parent/guardian through the persons listed on the emergency information form. (4) **If contact cannot be made with the parent or the child's physician, the school will do any or all of the following: a. call another physician; b. call an ambulance; c. have your child taken to the emergency facility by NSU campus police or by emergency services.**

Please initial: _____

Planning for Your Child and the Group

I permit my child's name to be noted on lesson plans and other school work.

Please initial: _____

Post Child's Information

I permit staff to post my child's information in areas only accessible by the staff, on physical condition, diet restrictions, and allergies.

Please initial: _____

Name and Contact Information Release Form

I permit to have my contact numbers and e-mail address on the family roster, to be distributed to parents of the children participating in this program.

Please do not include the following information on the family roster.

_____ Phone number _____ E-mail address

Please initial: _____

I have read and understand the above statements.

Signature of Parent/Guardian

Date

Norfolk State University
Child Development Lab
Child Photography and Video Consent and Release Form

I permit Norfolk State University Child Development Lab staff, Practicum Students, School of Education faculty/staff, and officials employed in the Office of News and Media Relations or Marketing Services at Norfolk State University to use any video clips, photographs, and audio recordings of my child. I understand that these images and recordings may be used for training, educational, research, and promotional purposes and that printed transcripts taken from these recordings may be made available. I understand that these images, recordings, and transcripts may be used in television broadcasts in the Commonwealth of Virginia and throughout the United States, and made available on websites, social media, and other technologies available now or hereafter developed.

I understand that I will receive no compensation for any use of the images and that the images can be archived for future use.

I hereby release Norfolk State University from any claims of liability regarding any use that may be made of the images following this Consent and Release.

I have read and understand the contents of this Consent and Release and have the right/authority to execute this document. I acknowledge and authorize that facsimiles of the original of this document, including my signature, shall be as valid as the original.

CHILD'S NAME (please print): _____

PARENT/GUARDIAN'S NAME: _____

SIGNATURE: _____ **DATE:** _____

Norfolk State University
Child Development Lab
Physical Activity Policy

The purpose of this policy is to ensure that children in this early care and education center are supported and encouraged to engage in active play, develop fundamental movement skills, and limit small screen recreation time in line with current public health recommendations as advised by Nemours Health and Prevention Services, a non-profit organization that works with families and community partners to help children grow up healthy.

Active and Inactive Play Time

- ✓ At least 120 minutes of active playtime is provided to all children each day. ✓
- Structured (teacher-led) play and unstructured play are provided to all children each day. ✓
- Infants are offered tummy time daily.
- ✓ Moderate-to-vigorous physical activity is encouraged during playtime for children. ✓
- Opportunities for outdoor play at least twice a day are offered for all children (weather permitting).
- ✓ Children are rarely seated for periods of more than 30 minutes without an activity break (excluding nap time).
- ✓ Active play time is not withheld for children who misbehave. Instead, we provide additional active playtime for good behavior.

Skill Development

- ✓ Children only participate in forms of physical activity that are developmentally appropriate.

Screen Time

- ✓ Children over the age of 2 have less than 30 minutes of screen time each week.
- ✓ We rarely show television and videos.

Play Environment

- ✓ We provide developmentally appropriate play equipment that is extensive and varied for children.
- ✓ Indoor and outdoor physical environments provide enough space and resources to allow for active play and practice of fundamental movement skills
- ✓ Outdoor play space includes an open, grassy area and a path for wheeled toys.
- ✓ Indoor play space is available for all activities, including running, when weather does not permit outdoor play.

Supporting Physical Activity

- ✓ Staff frequently encourage children to be active and often join children in active play.
- ✓ Posters, pictures, and books are used to provide visible support for physical activity in classrooms and common areas.
- ✓ Staff and students are required to wear appropriate shoes and clothing that allows for active participation in physical activity.
- ✓ Participatory forms of play are encouraged instead of competitive play.

Physical Activity Education

- ✓ We provide teacher-directed physical activity education for children, through a standardized curriculum, at least 1X a week or more.

Staff Training

- Information on the physical activity policy is included in the staff orientation.
- Training opportunities for staff on physical activity (other than playground safety) are offered at least once a year.

Parent Communication

- We communicate regularly with parents and provide information and advice on active play, fundamental movement skill development, and limiting small-screen recreation. For example newsletters, orientation days, information sessions, and informal discussions.
- We offer physical activity education to parents 2X per year or more.

Adapted from “Child Care Nutrition and Physical Activity Policies” by the NAP SACC Program, Center for Health Promotion and Disease Prevention, The University of North Carolina, Chapel Hill, NC, May 2007; and, “Best Practices for Physical Activity” by Nemours Health and Prevention Services, 2013.

Norfolk State University
Child Development Lab
Parent Agreement for Physical Activity Policy

By signing below, I acknowledge that I have received, fully read, and understood the attached **Physical Activity Policy**.

I declare that I have reviewed this policy and will do my best to support a healthy environment for my child at the NSU Child Development Lab and at home.

I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with staff.

Child's Name: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian

Date

Norfolk State University
Child Development Lab
Parent Authorization Form: Planning for your child and the group

I permit _____ initials to be noted on lesson
(Child's Name)
plans related to targeting activities.

Lesson plans are not posted

Parent/Guardian Signature

Date

Norfolk State University
Child Development Lab
Regulations and Policies Agreement
Parent Handbook Acknowledgement

I, the undersigned, acknowledge that I have read of the Parent Handbook for the Preschool Academy. While I understand that the Parent Handbook is neither a contract nor a legal document, I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Parent Handbook.

In addition, I understand that the contents of the Parent Handbook are subject to change. I acknowledge that the Parent Handbook will be revised following the rules or regulations of state, federal, and accrediting entities, best practices for child care service providers, or at the discretion of Norfolk State University. I recognize that any such revisions will supersede, modify, or eliminate the current contents of the Parent Handbook.

I acknowledge that it is my responsibility to stay informed of policy and procedure revisions to the Parent Handbook, which will be posted on the Preschool Academy website at <https://www.nsu.edu/pa>. In the event I do not have internet access, I understand that I can obtain a hard copy of the updated Parent Handbook upon request from the Preschool Academy.

Moreover, I recognize that it is my responsibility to contact the Preschool Academy's Program Director for any questions I might have about the contents of the Parent Handbook now and in the future.

Guardian Signature

Date

Child Registered in Program (1)

Child Registered in Program (2)

Child Registered in Program (3)

Child Registered in Program (4)

Handbook Revisions: 2013, 2014, 2015; 2017; 2023

Norfolk State University
Child Development Lab
Tuition and Activity Fee Agreement

The Norfolk State University Preschool Academy operates largely from the funds generated by the tuition paid for the children enrolled in the program. Therefore, all fees must be paid in full and on time.

The tuition for each school year is assessed on an annual basis. The tuition is payable in eleven (11) payments of **\$600.00 for full-time and \$400.00 for part-time**. The monthly payments may be divided into two (2) payments with authorization from the Program Director. The activity fee for the Fall/Spring semesters is **\$85.00** per child and is due in September. The Summer Program is held during June and July. A summer activity fee of **\$90.00** per child is required in May for students enrolled in the summer session. Employees of Norfolk State University may enroll in payroll deduction for tuition payments.

All checks should be made payable to Norfolk State University. The university charges **\$50.00** for all returned checks, and the University will not accept personal checks if one or more checks are returned.

The full or first half of monthly tuition is due on the first school day of each month. Parent/guardian will be notified of the past due amount after the five-day grace period. If payment has not been submitted after the five-day grace period, the late fee of \$40.00 will be applied to the tuition. Failure to submit the overdue payment may result in exclusion from the program.

Financial Agreement

I have read the Tuition and Activity Fee Agreement, and agree to comply with the Norfolk State University Preschool Academy regulations regarding fees and tuition payments.

Child's Name _____

Signed _____

Parent or Guardian

Date _____

We're Moving
Forward!



THANK YOU

Program Director

Dr. Ula Lyons

ulyons@nsu.edu

Daeja Godette - Preschool

Katrina Hines - Preschool TA

Jewel Holliman - Pre-K TA

Shirley Hoskins - Administrative

Alicia Wiggins - Pre-K

