GREENWICH PRESBYTERIAN PRESCHOOL

15400 Greenwich Church Way – physical address
15305 Vint Hill Road – mailing address
Nokesville, Virginia 20181
(703) 754-7933 ext. 210; www.greenwichpres.org

Child's Name ____
(Last) (First) (Middle)

Male ☐ Female ☐ Nickname (if any) ______________________

Name you wish your child to learn to write ______________________

Date of birth ______________ (Children must be 3 by 9/30/2025 to enroll in 3-year-old classes and 4 by 9/30/2025 to enroll in 4-year-old classes)

______ **2 Day 3-Year-Old (T,Th AM)** ______ **3 Day 3-Year-Old (M,W,F AM)**

______ **3 Day 4-Year-Old (T,W,Th AM)** ______ **5 Day 4-Year-Old (M-F AM)**

Address ____
Street/ Number City State Zip Code

*Primary Phone ________________ *Primary Email ________________

Mother's Name ______________________ Cell Phone ________________

Email Address ______________________ Address Same as Above (Y/N) ______

Place of Employment ______________________ Work Phone ________________

Father's Name ______________________ Cell Phone ________________

Email Address ______________________ Address Same as Above (Y/N) ______

Place of Employment ______________________ Work Phone ________________

Child's Known Allergies ______________________________________

EMERGENCY CONTACT: ______________________________________

Child's Physician ________________________________ Phone ____________________

Persons to be contacted in case you or emergency contact <u>cannot</u> be reached

1. ____ Phone _________________________

2. ____ Phone _________________________

Person(s) authorized to pick up child ____

____

Person(s) **NOT** authorized to pick up child _____________________________________

Previous preschools attended ____

Elementary school child will attend ____

Do you feel your child is right- or left-handed? __________________________________

Three-Year-Olds – approximate date potty trained ______________________________
(If not accomplished yet, please let us know when done)

Other children in the family (names and ages):

____

____

Please comment on anything (personal traits, special interests, or chronic physical/developmental difficulties) you would like your child's teacher to know

____

____

How did you hear about our preschool?

_____ Family is alumni of Greenwich Preschool; when: ______________________

_____ Friend or family member

_____ Attend Greenwich Presbyterian Church

_____ Social media or Other

GREENWICH PRESBYTERIAN PRESCHOOL

Policies

The registration fee of $125.00 per school year is due when the application is filed. The registration fee is refundable only when the Preschool deems it is unable to enroll a child. Please make checks payable to **Greenwich Presbyterian Preschool.**

The Preschool shall be notified immediately if a child is unable to attend the preschool. If during the school year a child is withdrawn, the parent must give the Preschool 30 days written notice to avoid payment of the next month's tuition.

The Preschool operates on a yearly budget. The yearly tuition for the two-day program is $1935.00, the three-day program is $2520.00 and the five-day program is $3600.00. Tuition payments have been divided into equal monthly payments, September through May. Therefore, monthly payments will remain the same regardless of holidays, absences, and snow days (up to two weeks).

Payment of $215.00 per child for the two-day program, $280.00 per child for the three-day program and $400.00 per child for the five-day program will be due the first day of preschool each month. **A late fee of $10.00 will be due if the payment if not received by the tenth day past the due date.**

Your child should be picked up at the scheduled time for the end of class. If your child is not picked up within 10 minutes of the scheduled time, you will be responsible for a $10.00 late fee due at the time the late pick up occurs. The late fee will apply if late pick up of the child results from lack of proper permission to release the child. You are responsible for giving written or verbal permission to the teachers or director to release the child to someone other than yourself if you are unable to pick up the child yourself.

Any child with a contagious illness or fever may not attend preschool until free of the illness or until the illness is no longer contagious and the fever has been absent for **24 hours.** Please contact us if you feel your child has exposed other children to any contagious illness or condition.

The Preschool reserves the privilege of dismissing any child if, after entering, the child seems unable to participate in group experiences.

Liability for a child's action while under care of the Preschool is the parents' responsibility.

The Preschool and Greenwich Presbyterian Church are not liable for accidents or illness occurring to the child while the child is in its care, unless proof is presented that the accident or illness was the direct result of the caretaker's negligence.

Parents must read and abide by the Greenwich Presbyterian Preschool Handbook, which will be provided upon entrance to the Preschool.

Parent/Guardian Signature ________________________________

Date __________

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Release Form

Child's Full Name____

Greenwich Presbyterian Preschool agrees to notify the parent/guardian whenever a child becomes ill, and the parent/guardian agrees to pick up the child as soon as feasible thereafter.

The parent/guardian authorizes Greenwich Presbyterian Preschool to obtain immediate medical care if an emergency occurs when he/she cannot be located immediately. This will be at the parent's expense.

In all emergencies, the Preschool has permission to take such reasonable measures as are, in the judgement of the teacher or director, necessary for the welfare and safety of the child.

Parents will provide the Preschool with the following documents:

- Birth Certificate or Adoption Papers
- VA School Entrance Health Form completed and signed by the child's physician
- Immunization Record

The parent or guardian agrees to abide by all Greenwich Presbyterian Preschool policies as stated in the policies form.

Parent/Guardian Signature ___________________________________

Date ____________________

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Registration Fee (non-refundable): $125.00
Note: If multiple children are registering from one family, only one registration fee is required.

Tuition for 2025 – 2026 School Year:

Two days:	$215.00 per month / $1,935.00 per year
Three days:	$280.00 per month / $2,520.00 per year
Five days:	$400.00 per month / $3,600.00 per year

Classes offered: 3 year olds:
Mon-Wed-Fri AM: 9:00-12:00
Tue-Thurs AM: 9:00-12:00

4-5 year olds:
Mon-Tue-Wed-Thurs-Fri AM: 9:00-12:00
Tue-Wed-Thurs AM: 9:00-12:00

School Year Starts:
Tuesday, September 2, 2025

Required Documents:
Immunization Record
VA School Entrance Health Form
Birth Certificate

Ages Accepted: 3 (by September 30, 2025) - 5 year olds

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 earlier 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 Code __________

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: ____-____-____

Hospital Preference: ______________

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐ __________

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies:**			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

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)			

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 Interpreter: ______________ Date ____/____/____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP	☐

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis A Vaccine	1	2			
Meningococcal ACWY Vaccine	1	2			
Meningococcal B Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

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.*):** 12 / /

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: ______________________________ Date of Birth: |____|____|____|
Parent or Legal Guardian Name: ______________________________
Parent or Legal Guardian Name: ______________________________
Phone Number: ______________________________

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:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

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

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

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

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

Signature of Medical Provider or Health Department Official:______________________________Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

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

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

(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

Student's Name: ______________________ Date of Birth: ____/____/________ Sex: M F

Health Assessment

Date of Assessment: ____/____/______

Weight: ________lbs. Height: ________ft. _______in.

Body Mass Index (BMI): ____________ BP ____________

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

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

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

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date: ________ TST Reading____ mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date: __________ Normal _ Abnormal

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

Blood Lead: ______________________ Hct/Hgb ______________________

Developmental Screen

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

Hearing Screen

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

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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

Summary of Findings (check one):

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

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

____

____**Allergy:** ☐ food:________ ☐ insect:______________ ☐ medicine:_________ ☐ other:____________

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

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

____**Restricted Activity Specify:** :______________________________

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: ______________

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

____**Special Diet Specify:** ______________________________

____**Special Needs Specify:** ______________________________

Other Comments: ______________________________

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: ______________________________ **Signature:** ____________________

Practice/Clinic Name: ____________________ **Address:** ______________________________

Phone: _____-______-________ **Fax:** _____-______-________ **Email:** ____________________