

Weekday Education Program
First Baptist Church, Collinsville, Virginia

2024/2025 school year
Application for Enrollment

Child's name _____ Name used at home _____

Date of birth _____ Sex _____ Class you are applying for _____
(Age as of August 31, Current Year)

Address _____ Phone No. _____

_____ Cell Phone No. _____

Can you receive texts: __Yes __No

Home Email Address _____

Father's Name _____

Home address: _____

Employer Name _____ Work Phone _____

Work address: _____

Mother's Name: _____

Home Address: _____

Employer Name _____ Work Phone: _____

Work address: _____

Religious Affiliation

Church you attend _____

If no membership, give church preference _____

Emergency Information

Name of Child's Physician _____ Phone No. _____

Person(s) authorized to act for parents in emergency (i.e., relative, etc.)

1. Name _____ Phone No. _____

Address _____ Relation to child _____

2. Name _____ Phone No. _____

Address _____ Relation to child _____

Does your child have any allergies? (food, insect, drug, latex, etc) _____

If so, to what _____

Does your child have any other medical condition we need to be aware of? _____

If so, what? _____

Person(s) authorized to pick up child _____

Person(s) NOT authorized to pick up child _____

Names & Ages of Other Children in Home _____

Has child attended another preschool program? _____

WEEKDAY EDUCATION PROGRAM

First Baptist Church
3339 Virginia Avenue
Collinsville, VA 24078

FIRST AID PERMISSION

Child's Name: _____

Age: _____

I give First Baptist Church Weekday Education Program staff permission to administer first aid to my child. In case of emergency, the school staff will promptly contact the parents. If neither the parent nor the emergency contact can be reached, and in case of surgical emergency, I hereby give permission to the physician selected by the Weekday Education Program Director to secure proper treatment for my child named above.

Signature: _____

(parent or guardian)

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				
	1	2	3	4	5
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)					
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)					
Tdap Vaccine booster					
Poliomyelitis Vaccine (IPV, OPV)					
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age					
Rotavirus Vaccine (RV) only for children < 8 months of age					
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age					
Varicella Vaccine			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)					
Measles Vaccine (Rubeola)			Serological Confirmation of Measles Immunity:		
Rubella Vaccine			Serological Confirmation of Rubella Immunity:		
Mumps Vaccine			Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used					
Hepatitis A Vaccine					
Meningococcal ACWY Vaccine					
Meningococcal B Vaccine					
Human Papillomavirus Vaccine (HPV)					
Influenza (Yearly)					
Other					
Other					

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 / /