DIVISION OF LICENSING PROGRAMS
DEPARTMENT OF SOCIAL SERVICES
CHILD REGISTRATION FORM (Model)

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 Phone
Mother	Place Employed	Business Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home 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 1.	Address 1.	Phone 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.

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) ***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.

2021-2022 EPWORTH DAY SCHOOL CONTRACT

In this contract between Epworth Day School (EDS) and the parent or guardian, we agree to enroll the following child:

____   _________________________________

Child's Name   *Date of Birth*

This contract is made and entered into this day, between the parent or guardian and Epworth Day School. I promise to pay to the order of Epworth Day School, in equal monthly, bi-monthly, or weekly installments by the first of each month until all installments are paid for. Because tuition and fees are the sole income of the school, I understand that **if I withdraw my child from the school during the year, I must give a 30-day written notice to the Director, or I am liable for the remainder of the tuition due for my contract, as well as all costs related to the collection of any outstanding fees and tuition. Financial** records will not be released and conference reports will not be issued until this balance is paid. Appeals for release from this payment may be made to, and will be decided entirely, at the discretion of the Epworth UM Church Council. Voluntary or discretional withdrawals will not be considered by the Church Council as representing grounds for consideration of release from payment of the annual balance due.

All tuition payments are paid on a monthly, bimonthly, or weekly basis. All monthly payments are due on the 1st of the month. Those making bi-monthly payments are due on the first of the month and the fifteenth of the month preceding care. Those making weekly payments are due the Friday before the following week of attendance. **A late fee of $50 is assessed on any payment received after 6 p.m. on the fifth of each month, the twentieth of each month, or on Monday's, after 6:00 p.m. as applicable.** Failure to keep my account current will result in dismissal of my child from the program and my account will be sent to collections. There is a $30.00 fee for all returned checks and any additional fees associated with the returned check.

All payments may be made by cash, check, MO, or PayPal. Please make all checks payable to EDS. Tuition may be paid in the office. Payments through PayPal are to the email address: epworth@epworthva.org.

Additional Fees: There is a **$100 non-refundable registration fee** (initial enrollment only). For each following school year, there will be a **$60 non-refundable annual fee to re-enroll. In addition, there is a $55 supply fee for each school year per child.**

This contract begins _________________________and expires on August 31, 2022.

There is no reduction in tuition for absences, days missed, holidays, inclement weather, or building issues. There are no refunds for fees paid. <u>All tuition is calculated for the entire school year by averaging the days open and then dividing them into equal monthly payments for the budget convenience for the parents.</u>

Epworth Day School is open 6:30 a.m. – 6:00 p.m. Monday through Friday. There is a **late pick up fee of $2 per minute after 6:00 p.m. according to the office clock.**

Parent/Guardian Email: Please note, your email will only be used for billing and EDS communication purposes.

_______________________________________   _______________________________________

Mother's email address   **Father's email address**

2021-2022 EDS TUITION AND FEES

FEES

Registration Fee: $100 (one-time)
Annual Re-Registration Fee (each September) = $60.00
Annual Supply Fee/Child = $55

FULL TIME CARE TUITION

ROOM	HOURS	FEE
Infant/Waddler/Toddler	6:30 am – 6 pm M-F	$935.00
2-Year-Old Rooms	6:30 am – 6 pm	$895.00
3- & 4-Year-Old Rooms	6:30 am – 6 pm	$860.00
All Day Kindergarten	9 am – 3 p.m.	$630
Before & After School Care (Kindergarten Only)	Before 9 am & after 3 pm	$100

PART TIME CARE TUITION

No part day/part week available for Infants/Waddlers/Toddlers

FIVE DAYS A WEEK *(up to 4 hours/day)*	**TWO DAYS A WEEK: (full days)**	**THREE DAYS A WEEK (full days)**
Twos - $575.00/month	Twos - $390/month	Twos - $565/month
Threes - $505.00 /month	Threes - $375/month	Threes - $545/month
Fours - $505.00/ month	Fours - $375/month	Fours - $545/month

I will pay the full monthly fee of ________________________________.

I will pay the full tuition in bi-monthly payments of_________________________

I will pay the full tuition in weekly payments of ____________________________.

Parents/Guardian Signature _________________________________ Date________________

CHILD'S EMERGENCY MEDICAL AUTHORIZATION

Name of Child: __________________________________ Birth Date: __________________

The Parent(s)/Guardian(s), of the above named child, authorizes EPWORTH DAY SCHOOL to obtain immediate medical care and consent to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to his/her child or ward if an emergency occurs when, and only when, I/We (parent/guardian) cannot be located immediately.

Otherwise, the parent/guardian of this child expects to be notified immediately.

1) **I/we will be responsible for payments of medical care expenses**

2) **Medical treatment costs are covered by:**

   a) **Private Insurance (Name of Insurance) _________________________________**

      Policy Number: ____

   b) **Medicaid Coverage Number: ____**

   c) **Other Medical Insurance:**

      Name of Insurance Company: _______________________________________

      Policy Number: ____

   d) **No Insurance: ________**

Child's Physician or Clinic attended: ____

Address of Physician or Clinic: ____

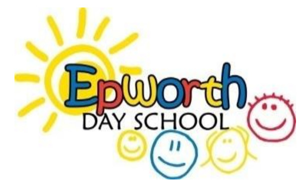
Phone Number of Physician or Clinic: ____

________________________________ ______________________
Signature of Parent/Guardian Date

________________________________ ______________________
Signature of Parent/Guardian Date

2021-2022 SCHEDULE EPWORTH DAY SCHOOL

124 West Freemason Street | Norfolk, VA 23510



SEPTEMBER 1st	OPEN HOUSE/MEET & GREET	
SEPTEMBER 2nd & 3rd	TEACHER TRAINING	CLOSED
SEPTEMBER 6th	LABOR DAY	CLOSED
SEPTEMBER 7th	CLASSES BEGIN	6:30 – 6:00
October 11th	COLUMBUS DAY	CLOSED
NOVEMBER 11TH	VETERAN'S DAY	CLOSED
NOVEMBER 24th	EARLY CLOSING AT 3:00 P.M.	EARLY CLOSURE
NOVEMBER 25th & 26th	THANKSGIVING HOLIDAYS	CLOSED
DECEMBER 23rd, 24th	CHRISTMAS HOLIDAYS	CLOSED
December 27th	EDS Reopens	6:30 a.m. – 6 p.m
December 31st	HAPPY NEW YEAR (almost)	CLOSED
JANUARY 17th	MARTIN LUTHER KING, JR.	CLOSED
FEBRUARY 21st	TEACHER WORK DAY	CLOSED
APRIL 15th	GOOD FRIDAY	CLOSED
APRIL 18th	MONDAY AFTER EASTER	CLOSED
MAY 30th	MEMORIAL DAY Observed	CLOSED
JUNE 9th	GRADUATION	SANCTUARY
JUNE 10th	TEACHER WORK DAY	CLOSED
JUNE 13th	SUMMER PROGRAM BEGINS	
June 20th	JUNETEENTH OBSERVED	Closed
JULY 4th	JULY 4th OBSERVED	CLOSED
AUGUST 31st	OPEN HOUSE/ MEET & GREET	
SEPTEMBER 1st & 2nd	TEACHER WORK DAYS/TRAINING	CLOSED
September 5th	LABOR DAY OBSERVED	CLOSED
SEPTEMBER 6th	CLASSES BEGIN	6:30 – 6:00

Sick Child and Illness Exclusion Policy

If your child is ill, please keep him/her at home. We play outside every day. **If you feel your child is not well enough to be outside, she/he is probably not well enough to come to school.** There are times when children must stay home. Please do not bring your child to school if your child has any of the following symptoms or illness:

- Heavy or discolored nasal discharge
- Sore throat
- Fever of 100 F or higher
- Vomiting
- Diarrhea
- Red or pink eye, including itching and discharge
- Impetigo
- Head Lice
- Ringworm
- Hand, Foot and Mouth Syndrome
- Or any contagious illness

Your child should not return to school until they have been symptom-free for at least 24 hours without the aid of medication. If your child was excluded from school with a fever, vomiting, or diarrhea, he/she will not be allowed attend school the following day. Furthermore, if you administer any type of fever reducer to your child to reduce their fever, they are not permitted to attend school that day.

If your child becomes ill at school, we will call you immediately and ask that they are picked up **within 30 minutes**. If we are unable to get in touch with you, your child's emergency contact(s) will be called to pick up your child; please keep your emergency contacts up-to-date.

Children who become ill during school hours must be isolated from others to prevent illness from spreading. Therefore, you may pick your child up in the office. Upon picking up your child, you will be asked to sign an **Illness Exclusion Form** that explains our return-to-school policy.

If your child is taken to their physician before returning to school, we ask that you call the school to report any communicable disease symptoms so we may inform other parents. Please note, the school *will not* disclose your child's identity when sharing this information. Families will be notified if there is an outbreak of any communicable disease at school.

If your child is unable to participate in any of the daily activities due to lethargy or is unable to stay awake and is not exhibiting any other symptoms, your child will be excluded from care.

If you have questions about whether your child can come to school, please call us at 757-313-5301. These policies will be strictly adhered to for the health and safety of all children attending EDS.

X ____________________________
Child's Name (Print)

X ____________________________
Parent or Guardian Signature / Date

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: ____________________ Current Grade: ____________

Student's Name: ____
Last First Middle

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

Student's Address: ____________________ City: ____________ State: ____________ Zip: ____________

Name of Mother or Legal Guardian: ____________________ Phone: ______-______-________ Work or Cell: _____-_____-______

Name of Father or Legal Guardian: ____________________ Phone: ______-______-________ Work or Cell: _____-_____-______

Emergency Contact: ____________________ Phone: ______-______-________ Work or Cell: _____-_____-______

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

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

____

____

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

____

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

Please provide the following information:

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

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

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

Signature of Parent or Legal Guardian: ____________________ Date: _______/________/ __________

Signature of person completing this form: ____________________ Date:_______/________/___________

Signature of Interpreter: ____________________ Date: ______/______/_________

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician, 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 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

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ❑ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Certification of Immunization 04/07

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:** __________

EDS Babysitting Release Form

I, ________________________________ (print name) understand that if I hire an employee of Epworth Day School to babysit my child/children outside of their scheduled working hours and off school/church premises, I will not hold Epworth United Methodist Church or Epworth Day School responsible for any liability for my child/children or personal property.

Parent or Guardian Signature ____

Date _______________________

EPWORTH DAY SCHOOL

A mission of Epworth United Methodist Church
124 West Freemason Street | Norfolk, VA 23510
757-313-5301

RELIGIOUS DISCLOSURE STATEMENT

I understand that Epworth Day School is a Christian mission of Epworth United Methodist Church. As such, I realize that my child will be introduced to Christian principles as a part of the curriculum at Epworth Day School.

My child may participate in programs celebrating Christian holidays and attend Children's Chapel at the appropriate age level. I realize that prayer at mealtime and Bible songs and stories will be introduced in the daily classroom gatherings.

___________________________________ ___________________________

Parent/Guardian Signature Date