BOXWOOD SCHOOL, INC

507 Winchester Street
Warrenton, VA 20186
(540) 905-9095

FEE SCHEDULE*

School and Day Camp

A. 3 Mornings @ $5,625.00 a year or $625.00 a month

B. 4 Mornings @ $5,850.00 a year or $650.00 a month

C. 5 Mornings @ $6,075.00 a year or $675.00 a month

D. 3 Full days @ $6,300.00 a year or $700.00 a month

E. 4 Full days @ $6,525.00 a year or $725.00 a month

F. 5 Full days @ $6,750.00 a year or $750.00 a month

TUITION DUE the first of the month, grace period until the 10th. **Tuition paid after the 10th will incur a $25.00 late fee.**

SCHOOL AND DAY CAMP hours are the following:
Mornings are 8:30 am to12:30 pm, Full days are 8:30 am to 3:00 pm.
FEE for early arrival (prior to 8:30 am) and/or late pickup (after 3:00 pm) is $10 an hour or any portion of an hour.

CAMP: Weekly Rate which includes Registration Fee
1 week $250.00 2-6 weeks $225.00 per week 7 plus weeks $200 per week
Half day $60.00 Full day $75.00

REGISTRATION FEES to cover materials/supplies due with registration and contract.
School Fee $125.00
Day Camp Fee $125.00

TUITION REDUCTION of 10% for each child after the first enrollment in a single family (excluding daily/weekly rates). Tuition can be adjusted if a parent serves as an aide and/or teacher.

SCHOOL CLOSINGS Follow the Fauquier County Public School (540-422-7250) advisories the first day, parent notification after that.
Parents use their judgment on early pickup when public schools warn of early closing.

*Prices are subject to change without notice.

THE BOXWOOD SCHOOL

507 Winchester Street
Warrenton, VA 20186
(540)347-1679

REGISTRATION FORM

Child's Full Name_____ Birthday_____

Nickname_____ Sex_____ Phone_____

Parent's Name_____

_____
Address

_____email address

Guardian's Name_____
(Individual having custody of the child in the absence of the natural parents.)

_____Phone_____
Address

Previous School Attended_____

Persons Authorized for daily pick-up:

_____ Phone_____

_____ Phone_____

Name of Persons NOT Authorized to pick up the child:

_____ _____

- - - - - - -

$125.00 Non-refundable Registration Fee must accompany this form to reserve a place for the 20_____ **Academic Year**.
Please *Circle* days of week attending Academic Year: M T W T F
Circle what type of school day you are registering for: ½ day or FULL day

$125.00 Non-refundable Registration Fee must accompany this form to reserve a place for the 20___ **Summer Day Camp**. Please Circle Session I II III or ALL.
Please *Circle* days of week attending Summer Day Camp: M T W T F
Circle what type of camp day you are registering for: ½ day or FULL day

_____Date_____

_____Date_____
Signature(s) of Person Financially Responsible for Tuition

ATTACH Contract along with Registration Fee, Emergency Medical Form, Emergency Preparedness Form, Photo Release, Pool Release and Health Form with Shot Records. Required by Law to Show Birth Certificate. *PLEASE fill out front and back of forms, leave NO section blank.*

11/15

Tell us about your child

Social Relations

Work Habits

Motor Development

Oral Language

Why do you want to come to Boxwood school?

Do you understand the basic principles of a Montessori Primary School?

Do you have any special concerns to be addressed?

BOXWOOD SCHOOL ENROLLMENT CONTRACT

This AGREEMENT made this _____ day of _____, 20_____, by and between the PARENTS,

_____and the BOXWOOD SCHOOL, INC.

WITNESSETH:
IN CONSIDERATION of the sum of $125.00, ***registration fee*** (non-refundable), cash in hand, paid by the PARENT to the SCHOOL, a place reserved for the academic year 20___ for the child named _____,
IN CONSIDERATION of the sum of $125.00, ***registration fee*** (non-refundable), a place is reserved for camp session I II III or All camp sessions in the year of 20 ___ for the child named _____.

IN CONSIDERATION of the instruction and care to be rendered by the SCHOOL to the above-named child, the PARENT hereby agrees and promises to pay the SCHOOL on or before the 10th of each month the tuition fee indicated in *Option (circle one) A B C D E F (see chart below).

The PARENT further agrees that enrollment is for the full school year, September through May, or for the balance of the school year as of the date of this agreement, and that the exceptions will be (a) if the child's family moves from the Warrenton area or (b) if the SCHOOL exercises its right to ask the PARENT to withdraw the child because in the SCHOOL'S judgment the child's presence proves to be detrimental to the health or progress of either the child or the other children in the school. In either event, the payment obligation will cease with the full payment for the month in which the withdrawal takes place.

The PARENT gives permission for the CHILD to take part in all school activities and field trips and hereby releases the SCHOOL from liability for any loss or damage sustained because of any injury to the CHILD during any such activities, field trips, or use of swimming pool. The SCHOOL will take all reasonable precautions with respect to insurance, selection of drivers, number of children per car, number of children per trip, and water safety.

The PARENT acknowledges responsibility for the CHILD'S s travel to and from the SCHOOL and his prompt arrival and departure in accordance with the scheduled school day and further acknowledges that any person designated by the PARENT to transport the CHILD will in no way be acting as an agent of the SCHOOL.

The PARENT will provide the SCHOOL with a copy of the child's Birth Certificate.

The PARENT acknowledges his responsibility to furnish state-required statements indicating the health of the above-named child and proof of his immunizations against communicable diseases. The PARENT further agrees to keep the child home when visible signs of illness appear and to remove him promptly in the event the child becomes ill at school. In the event of medical emergency at the SCHOOL when neither the PARENT nor the child's personal physician can be reached, the PARENT gives the SCHOOL permission to take such measures as it sees fit to assure the safety and comfort of the child.

WITNESS THE FOLLOWING SIGNATURES: ON THIS DATE _____

_____

_____ _____

PARENTS DIRECTRESS OF THE SCHOOL

ENROLLMENT OPTIONS: *Please circle your choice and write the letter above.
A. 3 morning's B. 4 morning's C. 5 morning's D. 3 days/week E. 4 days/week F. 5 days/ week

THE BOXWOOD SCHOOL

EMERGENCY MEDICAL AUTHORIZATION

Name of Child _____Date of Birth _____

Name of Parent(s) or Guardian _____Home Phone_____

Home Address _____
Street City State ZIP

Email Address mother_____father_____

MOTHER'S Place of Employment _____Work # _____ Cell #_____

Work Address_____
Street City State ZIP

FATHER'S Place of Employment _____ Work # _____ Cell #_____

Work Address _____
Street City State ZIP

The parent(s)/guardian authorizes THE BOXWOOD SCHOOL to obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to, his/her child if an emergency occurs when she/he cannot be located immediately. It is also understood that this agreement covers only those situations that are true emergencies and only when she/he cannot be reached. Otherwise she/he expects to be notified immediately.

1. I/We will be responsible for payment of medical expenses.

   _____Date _____
   Parent(s)/Guardian Signatures

2. Medical treatment costs are covered by:
   a. Blue Cross/Blue Shield Policy Number _____
   b. Medicaid coverage Number_____
   c. Other Medical Insurance Name _____
      Policy Number _____
   d. No Medical Insurance _____

Child's physician or clinic _____Phone _____

Physician's Address _____
Street City State ZIP

TWO EMERGENCY CONTACTS (in the event parent(s)/guardian cannot be reached) please call:

Name _____ Phone _____

Address _____
Street City State ZIP

Name _____ Phone _____

Address _____
Street City State ZIP

Allergies, Special Health Conditions _____

_____

_____

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 injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

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

_____

_____

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

_____

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

Please provide the following information:

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

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

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

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

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

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

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

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

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

Student's Name:_____ Date of Birth: |___ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

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

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

_____
_____
_____.

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

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

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

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

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

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

Section III
Requirements

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

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

Certification of Immunization 10/2010

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:** _____

THE BOXWOOD SCHOOL
507 Winchester Street, Warrenton, Virginia 20186
540/347-1679

POOL RELEASE

This RELEASE, made this _____ day of _____, _20___ by and between _____ (parents of minor) and a minor _____ (the child) and THE BOXWOOD SCHOOL, INC., Elizabeth G. Coffin, Directress, her heirs, executors, employees, agents and assigns (the school and owners),

WITNESSETH:

THAT in consideration of the school and owners making available, for general recreational purposes, the swimming pool on their premises at 507 Winchester Street, Warrenton, Virginia for use by the parent and/or the child to the school and owners, the parties do hereby agree to RELEASE each other from any and all claims for liability for personal injury, death, or property damages arising from use of the pool during

the period of _____ through _____, _20____.

THIS RELEASE INCLUDES all matters pertaining to the losses aforesaid, from any cause, and whether or not specifically mentioned.

FURTHER, the parent agrees to specify the level of swimming experience and competence for the purposes of maximum protection to each swimmer, of any age.

THUS:

BEGINNER _____ INTERMEDIATE _____ EXPERIENCED _____ ADVANCED _____

I authorize BW staff to administer (and teach my child how to put their) sunscreen and insect repellant on my child as needed.

_____
Parent Signature

_____
THE BOXWOOD SCHOOL, INC. by Elizabeth G. Coffin, Directress

2/16/11

EMERGENCY PREPAREDNESS PLAN

BOXWOOD SCHOOL

(Parent request form for action of child)

NAME OF CHILD _____

In the event of a natural disaster and/or other type of disaster, what method would you like to choose for your child during this emergency?

Please choose below and fill in any details that you can in the space provided.

_____ Stay at Boxwood or with staff until the disaster is over.

_____ Pick your child up as soon as you can.

_____ Release your child to: _____

_____ _____

Signature of Parent/Guardian Date

DETAILS:

Please return this form along with the registration/contract forms for enrollment.

5/25/15

BOXWOOD SCHOOL
PHOTO RELEASE

I do give Boxwood School permission to take photographs of my child/ren.

_____

I do not give Boxwood School permission to take photographs of my child/ren.

_____