Weekday Education Program
First Baptist Church, Collinsville, Virginia

2025/2026 school year
Application for Enrollment

Child's name_____Name used at home_____

Date of birth_____Sex_____Class you are applying for_____
(Age as of September 30, 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				
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 /__ /____