Welcome to Pear Tree School!

Dear Parents and Guardians,

Welcome to the Pear Tree family! We are so excited to have you and your little one join our vibrant and nurturing community. At Pear Tree School, we believe that early childhood is a magical time filled with curiosity, discovery, and joy. We're honored to be part of this special journey with your child.

Our dedicated teachers and staff are committed to creating a safe, inclusive, and enriching environment where every child can grow, learn, and thrive. From hands-on learning experiences to creative play and social development, we focus on the whole child, supporting not just academic readiness, but also emotional and social growth.

We know that starting preschool is a big step, and we want you to feel confident and supported every step of the way. Communication is key, and we look forward to partnering with you to ensure a smooth and joyful transition into school life.

We kindly ask that you print and fill these forms out and have them with you for the first day of school.

Thank you for choosing Pear Tree School. We're thrilled to welcome you into our community, and we can't wait to watch your child bloom!

Child Registration Form

- **INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.**
- **THE INFORMATION IN THIS FORM IS REQUIRED BY CHILD DAY CENTER STANDARDS 8VAC20-780-60.**

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 or Class Level

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address		Home Phone
Parent	Place Employed	Work Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work 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 (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's 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 emergency 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***

First Date of Attendance: _____ Last Date of Attendance: _____

** 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 § 22.1-289.049 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..

12/2024

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:

Type	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

A copy of child's immunization records are attached ☐

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 official of health department indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording the dates on this page, as long as the completed immunization record is attached to the School Entrance Health Form: Part II Certification of Immunization (MCH213G).

As per 12VAC5-110-70, the Certification of Immunization form must be signed and dated by the Medical Provider (physician or designee, registered nurse, or official of the health department) in the appropriate box below. Contact 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.*):** __/__/____

Section II
Conditional Enrollment and Exemptions

A qualified licensed physician, nurse practitioner, or physician assistant must 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 (or 180 days for Hepatitis B). **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 https://www.vdh.virginia.gov/immunization/requirements/

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 and sign 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.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans/

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::_____

____I**ndividualized 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/Date:**_____

Practice / Clinic: **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

Statement for Special Diet Prescription - VDH

The following child is a participant in one of the United Stated Department of Agriculture (USDA) programs: National School Lunch Program School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

Part 1: To be completed by Parent/Guardian

Child's Name	Date of Birth	M F
Name of School/Center/Program:	Grade Level/Classroom:	
Parent's/Guardian's Name	In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act I hereby authorize [Insert name of physician/medical authority] to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to [Insert School/Program Name] and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on [Insert date]. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent; guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person. Parent/Guardian Signature:_____
( ) Home Phone / ( ) Work Phone		
Address		
City, ST ZIP Code	Date:_____	

Part 2: To be completed by Physician/Medical Authority

Does the child have a disability? Yes_____ No_____ If Yes, please describe the major life activities affected by the disability.	Does the child have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.
If the child is not disabled, does the child have special nutritional or feeding needs? Yes_____ No_____ If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.	Does the child require emergency medication be administered? Yes_____ No_____ If yes, please list medication(s) and describe situation/reactions that would necessitate administrating.

Part 3: To be completed by Physician/Medical Authority

List any dietary restrictions or special diet:

List any food allergies or food intolerances:		
List foods to be substituted (mandatory):		
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All". Cut up/chopped into bite sized pieces: Finely Ground: Pureed:		
List any special equipment or utensils needed:		
Indicate any other comments about the child's eating or feeding patterns:		
Physician's Name and Office Phone Number:		Office Stamp
Physician's/Medical Authority Signature		Date
Part 4: Parent Signature		
Parent's/Guardian's Signature		Date
Part 5: Program Signature		
School/Program Official Signature		Date

*Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Authorization Form for Non-prescription Over-the-Counter Skin Products

INSTRUCTIONS:
This form must be completed by the parent/guardian to authorize the use of:

- Sunscreen
- Diaper ointment or cream
- Insect repellent

_____ has my permission to apply the non-prescription
(Name of Provider)

over-the-counter (OTC) skin product listed below to my child, _____.
(Child's name)

Product Name: _____

Known Adverse Reactions (if any): _____

_____

- All OTC products must:
  - Be in the original container and, if provided by the parent, labeled with the child's name
  - Be used according to manufacturer's recommendation and instructions for application
  - Not be used beyond the expiration date of the product

- Sunscreen:
  - Must have a minimum sunburn protection factor (SPF) of 15
  - Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
  - Children nine yrs. and older may self administer sunscreen if supervised

- Diaper ointment/cream and Insect repellents:
  - Shall be kept inaccessible to children
  - Record of use shall be kept that includes child's name, date, frequency of application, and any adverse reactions

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Parent's Signature: _____ Date: _____

032-05-0430-00-eng (06/12)

Allergy/Food Permission Form

I (Parent/Guardian Name) _____ give/decline permission for my child _____ to participate in food related activities and special occasions wherein food is consumed.

****

Please provide the following information: Please initial only 1 choice.

___ My child DOES NOT have a food allergy or dietary restriction. He or she MAY participate in activities.

___ School Pizza Lunch

__ Classroom Celebrations

___ My child DOES have a food allergy or dietary restriction. He or she MAY NOT participate in activities.

****

Please provide the following information: Please initial only 1 choice.

__ My child DOES have a food allergy or dietary restriction. He or she MAY NOT participate in activities, and may not eat or handle the following item(s) listed below:

_____

_____

****

I understand that it is my responsibility to update this form in the event that my decision for permission changes or if my child is diagnosed with a new/different allergy. I agree that this form will remain in effect during the term of my child's enrollment.

Parent/ Guardian Name _____

Parent/Guardian Signature _____

Consent for
Medical/Surgical Care/Emergency Treatment
and Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: _____for _____
☐ Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter

of _____ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to _____
(Name of Person/Agency)

who will be caring for our (my) child _____
(Name of Child)

for the period _____ to _____ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____

Address: _____

_____

Telephone no.: _____

Name of health insurance carrier: _____

_____

_____

Group no.: _____

Agreement no.: _____

Family physician: _____

Pediatrician: _____

Surgeon: _____

Orthopedist: _____

Child's allergies, if any: _____

_____

Date of last tetanus booster: _____

Medicines child is taking: _____

_____

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

In case of emergency I can be reached at: _____

_____

_____

Daycare Photography Release Form

Peartree School

I, _____, parent of children attending the Peartree School, acknowledge and agree to the following:

• I understand that my children whose name(s) are listed below may be photographed at the Peartree School during regular daycare hours, field trips, and activities.

• I understand that these photographs may be used in arts & crafts and for children to take home as memorabilia. They may also be used for the purpose of promoting and marketing the Pear Tree School and may be used on but not limited to; the Pear Tree School's website, Facebook, Instagram, print advertising, etc. A first name may be mentioned, and surnames will be omitted.

The following are the names of my children attending the Pear Tree School: 1.

_____

2._____

3._____

4._____

(_) Yes, I confirm that I have read and understand the above and agree to have my child(ren)'s photos used for the purpose of keeping parents informed of the Pear Tree School happenings and for the purpose of marketing for Pear Tree School.

(_) No, I do not wish to have my child (ren)'s photographs published

Name (print) _____ Date:_____

Signature:_____

Pear Tree School 6223
Patrick Henry Blvd Bealeton,
VA | 22712
thepeartreeschool.com

THE PEAR TREE SCHOOL

6223 Patrick Henry Blvd Bealeton, VA 22712
Telephone: 540-439-5032

CHILD EMERGENCY FORM

Child's Name	**DOB**	**Nickname**
Home Address	**Home Telephone**	
City	**State**	**Zip Code**
Previous School (if any)		

Mother's Name	**Home Number**	
Home Address	**Cell Number**	
City	**State**	**Zip Code**
Employer	**Employer Number**	

Father's Name	**Home Number**	
Home Number	**Cell Number**	
City	**State**	**Zip Code**
Employer	**Employer Number**	

2. Allergies or Medication & Action to take in an Emergency.

_____

3. Emergency Contacts (in the event of an emergency & you are unable to pick up your child you are required to provide designated persons. (NOT Mother/Father)

Name	**Name**
Home Address	**Home Address**
City, State, Zip Code	**City, State, Zip Code**
Telephone	**Telephone**
Relationship to Child	**Relationship to Child**
Persons Authorized for Pick-up	
Persons Unauthorized for Pick-up	
Physician's Name	**Physician's Telephone**

Parent's Signature_____ **Date**_____