

Arlington Children's Center

1915 North Uhle Street Arlington, VA22201

(703)-528-5588

www.arlingtonchildrenscenter.com

REGISTRATION FORM

Child Name	Last	First	Middle	Nickname	Date of Birth	Sex	
						F	M
Address					Home Phone#		
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed							
Previous Child Day Care Programs and Schools Attended							
E- mail address - print							
Father			Business Phone#			Cell Phone#	
Home Address					Home Phone#		
Mother			Business Phone			Cell Phone #	
Home Address					Home Phone		
Person(s) or Agency Having Legal Custody of Child							
Address					Phone#		
Business Address					Business Phone# Cell Phone#		

Appropriate paperwork such as custody papers shall be attached if parent is not allowed to pick up the child

EMERGENCY INFORMATION

Two authorized people to contact if parent(s) cannot be reached			
1. First &last name			
Address: Street	City	Zip	Phone#
2. First &last name			
Address: Street	City	Zip	Phone#

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 Day Care Center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **
3. Other _____

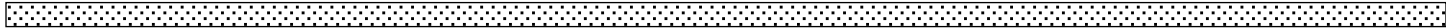
PLEASE BRING BIRTH CERTIFICATE OR OTHER PROOF OF IDENTITY OF YOUR CHILD

SIGNATURES

<i>Parent(s) or Guardian(s)</i>	<i>Date</i>
<i>Administrator of Center</i>	<i>Date</i>

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 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.

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PRE-ADMISSION FORM

Date: _____

Child's Name _____
(Last) (First) (Middle)

Sex: M ____ F ____

Child's Preferred Name _____

Complete Address _____

Home Number _____ Birth Date _____ Age _____
m/d/y

Admission Date _____ Termination Date _____

Father's Name _____
(Last) (First) (Middle)

Occupation _____ Company _____

Business Address _____

Business Phone# _____ Cell Phone# _____

Mother's Name _____
(Last) (First) (Middle)

Occupation _____ Company _____

Business Address _____

Business Phone# _____ Cell Phone# _____

Parents Married? _____ Separated? _____ Divorced? _____ Single? _____

Please list persons authorized to pick up your child:

Proof of identity is required at pick up

Is there anyone whom you do not wish to pick up your child? _____
If so, please give name and relationship to child.

Name: _____ Relationship to child: _____

Other members of the family (brothers, Sisters, grandparents, etc.) living at home:

Name Age Relationship Indicate Name Used by Child

Other members of the family (grandparents, aunts, uncles; etc.) living in the community:

Name Age Relationship Indicate Name Used by Child

Has your child had any previous school experience? _____

If so, please give name and type of school:

_____ Length of attendance _____

Does your child take a nap? _____ Morning _____ Afternoon _____

How many hours your child sleeps at night? (approximately) _____

Is your child toilet trained? _____ Does your child use any special wording for toileting? _____

If so please state _____

Describe your child's appetite: always hungry _____ eats at mealtime _____ snacks _____

Snack all day _____ never hungry _____ has to be coaxed to eat _____

Are there any foods your child may not or can not eat? (due to allergies, religious customs, etc.) _____

Are there any foods your child dislikes? _____ If so, please list _____

Special interests: singing _____ music _____ dancing _____ books _____ puzzles _____ Blocks _____

coloring/drawing _____ outside play _____ Other _____

Is your child generally cooperative? _____ shy? _____ competitive? _____

aggressive? _____ sensitive? _____ submissive? _____ angry? _____ happy? _____

usually does what is asked of him/her? _____ seldom does what is asked of him/her? _____

whines? _____ List other behaviors characteristic of your child. _____

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Child's Emergency Medical Authorization

Name of Child _____ Birth date _____

Name of Parent(s) or Guardian _____

Home Address _____ Telephone _____

Place of Mother Employment _____ Telephone _____

Address _____

Place of Father Employment _____ Telephone _____

Address _____

The Parent(s) Guardian authorizes _____

(Name of Day Care Center Operator)

to obtain immediate medical care and consents 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 he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for the payment of medical care expenses: _____

2. Medical treatment cost are covered by:

a. Name of the Insurance Company _____

b. Policy # _____

c. No Insurance _____

Child's physician or clinic attended: _____

Name

Phone#

(Parent(s)/Guardian signature _____ Date _____

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Health History

PROVIDED BY PARENTS

Name: _____

Birth Date: __/__/____ Sex: _____

Medical history

Diseases:

	age		age
Asthma	_____	Pneumonia	_____
Chicken Pox	_____	Whooping Cough	_____
Heart Disorder	_____	Diphtheria	_____
Measles	_____	Mumps	_____
Rubella	_____	Other	_____

Congenital Malformations _____

Drug Sensitivities _____

Seizures _____

Allergies (drug, food, etc.) _____

Comments _____

Parent's signature _____ Date _____

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Allergies History Form

Name of Child: _____ Date: _____

Allergies (please specify)

Foods:

Reactions:

Drugs:

Reactions:

Environment:

Reactions:

Treatment

Prevention:

Medication Daily:

Special circumstances (specify):

What to do if severe reaction occurs:

Signature: _____ Telephone: _____

Review date: _____

(The director and the child's parent(s)/guardians are advised to review this information every six months).

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Parent Agreement and Activities Permission

Parents please sign and return to the office

Child's Name: _____

PARENTS AGREEMENT:

1. I have read and understand the Parent Handbook, including all the policies, procedures, philosophy, and curriculum.
2. I understand tuition payment policy.
3. I agree to follow all policies while my child is enrolled at the Center
4. As stated in Virginia licensing provisions, I agree to pick up my child from the Center within an hour of notification for the following:
 - A temperature over 100 degrees
 - Suspicion of communicable diseases
 - Diarrhea/vomiting or other health problems
 - Behavior problems
5. As per state requirements I will notify the Center & CDC in 24 hours or next business day if my child or any member of the immediate household has developed any reportable communicable disease, as defined by The State Board of Health, except for life threatening diseases which must be reported immediately.
6. I agree that diaper ointment will be applied as needed by the staff
7. I have reviewed the Emergency Preparedness Plan developed with the state guidelines

PHOTO WAIVER

I give permission for my child's photo to be used in any promotional piece, such as a brochure, web-site or newspaper advertisement, only for the purpose of promoting the Center's programs*.

PLAYGROUND, WALKS AND OUTDOOR ACTIVITIES CONSENT

I, the undersigned, grant permission for my child to participate in playground, walks, and outdoor activities which may be scheduled in connection with Arlington Children's Center, knowing that every safety precaution will be observed, but that the Center cannot assume liability incurred in the conduct of this activity. Therefore, I grant my permission for my child to participate in the activities and in the use of the equipment at the Center and playgrounds.

PARENT/GUARDIAN _____

*Note: Throughout our school day we often take photos of the children enjoying special activities or projects. Most of these photos are used for bulletin board displays or special "sent home" items. Occasionally, we use a photo in one of our promotional venues (such as a brochure or web-site).