First Baptist Church of Clarendon Child Development Center

# *Enrollment Form*

2025-2026

All fields must be completed, please do not leave blank spaces. If the response is "not applicable" indicate so by writing N/A.

Name of Child _____ Nickname _____

Date of Birth _____ Current Age _____ Sex _____

Home Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ ☐ W ☐ H ☐ C Primary language(s) Spoken at home _____

Preferred Pronouns _____ Cultural and/or Religious Beliefs _____

Does child live with both parents? ☐ Y ☐ N *If yes, write "Same as above" on all applicable lines*

*If no, who is the primary contact?* _____

Parent's Name _____
Relationship _____
Address _____
City/State/Zip _____

Primary Phone _____ ☐W ☐ H ☐ C
Secondary Phone _____ ☐W ☐ H ☐ C

Primary Email _____
Occupation _____
Employer _____
Employer's Phone _____

Parent's Name _____
Relationship _____
Address _____
City/State/Zip _____

Primary Phone _____ ☐W ☐ H ☐ C
Secondary Phone _____ ☐W ☐ H ☐ C

Primary Email _____
Occupation _____
Employer _____
Employer's Phone _____

Which parent(s) will be responsible for tuition payment and other financial matters? _____

Please Select an Option: ☐Full-time Enrollment ☐Part-Time Enrollment

*If part-time, which days* ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri.

If another adult cares for your child during the day, please provide:

Full Name _____ Relationship _____ Primary Phone _____
Full Name _____ Relationship _____ Primary Phone _____

1306 N. Highland Street Arlington, VA 22201 Phone: 703-522-6477 Fax: 703-5227142

Persons authorized to pick up child (other than parents):

| Name | Relationship | Primary Phone |
|---|---|---|
| | | |
| | | |

Please list siblings:

| Name | School | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Does your child have any known drug allergies? ☐Yes ☐ None known

If yes, please list: _____

Does your child have any known food allergies? *Additional paperwork required* ☐Yes ☐ None known

If yes, please list: _____

Does your child have any known food sensitivities? *Additional paperwork required* ☐Yes ☐ None known

If yes, please list: _____

Does your child have any dietary restrictions? ☐Yes ☐ None

If yes, please list: _____

Does your child have any known environmental allergies? ☐Yes ☐ None known

If yes, please list: _____

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What previous experience does your child have with caregivers other than parents? *Please fill all that apply.*

A. Extended Family

| Name | Relationship | Age of child during this time |
|---|---|---|
| 1. | | |
| 2. | | |

B. Home-based childcare by an unrelated adult

| Name | Contact Information | Age of child during this time |
|---|---|---|
| 1. | | |
| 2. | | |

C. Full-time or part-time care at another daycare facility

| Name | Contact information | Age of child during this time |
|---|---|---|
| 1. | | |
| 2. | | |

When and where was your child's last classroom experience?

So that we may better serve your child, please provide any medical, developmental, or psychological information of which we should be made aware of. Kindly explain any professional assistance/support that your child has received.

If assessment have been performed on your child, in relation to above matter, please indicate your willingness to review those reports with CDC staff.

☐ Yes ☐ No ☐ Not Applicable

Signature of Parent/Legal Guardian Date

Signature of Parent/Legal Guardian Date

*Administrative Use Only*

Family has met with the Executive Director and /or member of the administrative team. Initial: Date:

Date of Enrollment: Start Date:

Classroom Assignment:

Document of identity:

Virginia School Entrance Health Form ☐Yes ☐No Date of Assessment:

Policy Statement Signed: ☐Yes ☐No Handbook Received ☐Yes ☐No

Enrolled by: Withdrawal Date:

First Baptist Church of Clarendon Child Development Center

# *Emergency Information*

2025-2026

All fields must be completed, please do not leave blank spaces. If the response is "not applicable" indicate so by writing N/A.

Name of Child: _____ Date: _____

Allergies: _____

Action to be taken in the event of an emergency: _____

Sensitivities to food, medication, etc.: _____

Action to be taken in the event of an emergency: _____

Child's Physician: _____

Address: _____ Phone: _____

Please list two people to contact if parents cannot be reached in the event of an emergency. **An address and phone number must be provided for both emergency contacts. ***

1. Name: _____ Relationship: _____

*Address: _____

Primary Phone: _____ ☐H ☐C ☐W Secondary Phone: _____ ☐H ☐C ☐W

2. Name: _____ Relationship: _____

*Address: _____

Primary Phone: _____ ☐H ☐C ☐W Secondary Phone: _____ ☐H ☐C ☐W

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 a child.*

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# *Emergency Medical Authorization*

2025-2026

All fields must be completed, please do not leave blank spaces. If the response is "not applicable" indicate so by writing N/A.

Name of Child: _____ Date of Birth _____

Name of Parent(s) or Legal Guardian(s): _____

Home Address _____

City _____ State _____ Zip Code _____

| | | | |
|---|---|---|---|
| Parent's Name: | _____ | Parent's Name: | _____ |
| Relationship: | _____ | Relationship: | _____ |
| Employer: | _____ | Employer: | _____ |
| Employer Address: | _____ | Employer Address: | _____ |
| Employer's Phone | _____ | Employer's Phone | _____ |

The Parent(s)/Legal Guardian(s) authorizes: First Baptist Church of Clarendon Child Development Center

*(Name of Childcare Provider)*

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 in the 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 costs are covered by:
    a. Name of Insurance Company: _____
        i. Medical Coverage No.: _____
        ii. Group/Policy/Other No.: _____
    b. Not insured: _____
3. Child's Physician or Clinic Attended: _____

*Must be signed in the presence of a Notary Public*

Signature of Parent(s)/Legal Guardians _____ Date: _____

*The foregoing instrument was acknowledged before me this* _____ *day of* _____, *20* _____

***OFFICE USE ONLY***

# IDENTITY VERIFICATION FORM

Please bring proof of identity (See the bottom of page for acceptable documentation) for the admin team to fill in the following information. A copy of your documents will not be kept on site.

Child's Name: _____ _____ _____
Last Name First Name Middle

| | |
|---|---|
| Place of Birth: | |
| Date of Birth: | |
| Form of Proof: | |
| Document Number: | |
| Date Issued: | |

| | |
|---|---|
| Date Documentation Viewed: | |
| Person Viewing Documentation: | |
| Date of Local Law-Enforcement Agency: | |
| When proof of identity is not provided: | |

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, 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. before school program). While programs are not required to keep proof of the child's identity, documentation of viewing this information must be maintained for each child.

First Baptist Church of Clarendon Child Development Center

# HEALTH HISTORY

2025-2026

PROVIDED BY PARENT/LEGAL GUARDIAN

All fields must be completed, please do not leave blank spaces. If the response is 'not applicable', indicate so by writing N/A.

Name of Child: _____

Date of Birth: _____ Sex: _____

## MEDICAL HISTORY

Please indicate if your child now has or has ever had:

| | Yes | No | If yes, at what age | | Yes | No | If yes, at what age |
|---|---|---|---|---|---|---|---|
| Asthma | ☐ | ☐ | _____ | Pneumonia | ☐ | ☐ | _____ |
| Chicken Pox | ☐ | ☐ | _____ | Whooping Cough | ☐ | ☐ | _____ |
| Heart Disorder | ☐ | ☐ | _____ | Diphtheria | ☐ | ☐ | _____ |
| Measles | ☐ | ☐ | _____ | Mumps | ☐ | ☐ | _____ |
| Rubella | ☐ | ☐ | _____ | Other: | ☐ | ☐ | _____ |

Please indicate if your child now has or has ever had any of the below, please elaborate:

Congenital Malformation _____

Known Drug Allergies _____

Food Allergies _____

Known Allergies _____

Drug Sensitivities _____

*Comments:* _____

Food Sensitivities _____

*Comments:* _____

Known Other _____

_____ _____

Signature of Parent/Legal Guardian Date

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# HEALTH REQUIREMENTS

2025-2026

PARENT/LEGAL GUARDIAN SIGNATURE REQUIRED

Name of Child: _____

Upon enrollment of each child, parent/legal guardian must submit a completed medical form signed by that child's physician.

EFFECTIVE IMMEDIATELY:

All children 6 months of age and older entering an Arlington County licensed Child Care Facility will be required to provide proof of a negative risk assessment for tuberculosis infection or the results of a Tuberculosis Skin Test (TST).

NOTICE:

Updated Commonwealth of Virginia School Entrance Health Form must be submitted every 6 months for children under 2 years of age (until their 2nd birthday) and annually for children over 2 years old. All children at the FBCC CDC are required to have and submit proof of an annual physical.

Please initial next to each of the following to acknowledge that you understand and agree to adhere to each of the listed policies.

_____ It is the responsibility of the parent/legal guardian to obtain from the FBCC CDC the form on which this information is to be documented. Failure to submit this form will result in the child being excluded from enrollment in the FBCC CDC.

_____ A health screening will be conducted as each child arrives, prior to them joining a larger group of children. If there are indications or present symptoms of illness, the child will not be admitted to school until free of the indications or present symptoms of illness.

_____ In the interest of the health, safety, welfare and wellbeing of your child in relationship to and with the other children in their same care setting and the FBCC CDC taken as a whole, we ask you to adhere to the following guidelines as policy. If your child has been exposed to any of the diseases and/or illnesses listed below while they are away from the FBCC CDC, we ask that you notify us of exposure. If your child shows any of the symptoms listed below, you will be called to come and pick up your child within 60 minutes of contacting you.

Symptoms include:

- A severe runny nose, cough, or sore throat
- An undetermined rash which is determined to require diagnosis and/or medication
- Temperature of 100 degrees or higher when taken in the ear
- Severe headache
- Stiff neck
- Upset stomach, regurgitation
- Diarrhea (3 loose movements in 2 hours
- Signs of extreme fatigue and general ill feeling

- Knowledge that child has had fever within past 24 hours
- Symptoms consistent with conjunctivitis (pink eye)
- Difficult or rapid breathing (especially in infants)
- Unusually dark, tea-colored urine-especially with a fever
- Itching of the head when lice is suspected or confirmed

Specific Illnesses

_____ The FBCC CDC will inform parents/legal guardians of communicable diseases that occur in their child's classroom. Any school wide notifications will be given only if it is advised by the Arlington County Public Health Department and with the approval of the Executive Director of the FBCC CDC.

_____ It is the policy of the FBCC CDC that children who have been ill with these specific illnesses will be readmitted to the FBCC CDC according to the following guidelines:

- Chicken Pox - When the last mark has scabbed over and after an inspection by the Assistant Director or a member of the Administrative Team
- Conjunctivitis - 24 hours after first dosage of medication
- Diarrhea or Vomiting - 24 hours after last loose stool or no more vomiting
- Ear Infection - 24 hours after first dosage of medication; if a fever is present, 24 hours after temperature is normal WITHOUT the aid of fever reducing medication
- Fever* - 24 hours after temperature is normal WITHOUT the aid of fever reducing medication

_____ Until further notice, per COVID protocols, 72 hours after temperature is normal WITHOUT the aid of fever reducing medication

- Hand, Foot and Mouth Disease - When the last blister is dry and scabbed and there are no more blisters in the mouth and only after an inspection by the Assistant Director or a member of the Administrative Team
- Head Lice - May not return to school for 24 hours and until a full treatment (generally considered to be 3 applications) has been applied to the head and only after an inspection of the head by the Assistant Director or member of the Administrative Team has determined the absence of lice, eggs and larva.
- Strep Throat - 48 hours after first dosage of medication
- Thrush - 24 hours after first dosage of medication

_____ Parents/Legal Guardians must notify the FBCC CDC within 24 hours or the next business day after his/her child or any member of the immediate household has developed any reportable communicable disease, as determined by the State Board of Health, except for life threatening diseases, which must be reported immediately. All children's medical/health issues are confidential.

_____ The FBCC CDC reserves the right to determine when in the best interest of the health, safety, welfare and wellbeing of other children enrolled as well as its employees to deny admittance to any child whose Medical Doctor/Professional has deemed the child could return to care during or following treatment.

By signing below, I acknowledge that I have received the Health Requirements and agree to follow the guidelines to help provide a healthy environment for my child.

_____ _____

Signature of Parent/Legal Guardian Date

First Baptist Church of Clarendon Child Development Center

# PARENT/LEGAL GUARDIAN AGREEMENT & ACTIVITIES PERMISSION

2025-2026

Name of Child: _____ Classroom Assignment: _____

Please initial next to each of the following to acknowledge that you understand and accept each of the listed policies.

## PARENT/LEGAL GUARDIAN AGREEMENT

Initials: _____

- I have read and understand the Parent Handbook., including all the policies, procedures and philosophies.
- I understand the tuition payment policy.
- I agree to follow all policies while my child is enrolled at the FBCC CDC.
- As stated in Virginia licensing provisions, I agree to pick up my child from the FBCC CDC within 60 minutes of notification of the following:
    - A temperature over 100 degrees
    - Suspicion of communicable diseases
    - Diarrhea/vomiting or other health problems
    - Behavior problems
- As per State requirements I will notify the FBCC CDC within 24 hours of any exposure to reportable communicable diseases.
- I agree that diaper ointment will be applied as needed by the staff with the appropriate signed paperwork.

## PHOTO WAIVER

Initials: _____

I give permission for my child's photo to be used in any promotional piece, such as a brochure, website or newspaper advertisement, only for the purpose of promoting the FBCC CDC's programs.

□ Yes □No

I give permission for my child's photo to be used for internal center use and classroom documentation*

□ Yes □No

**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.*

## OUTDOOR CLASSROOM, WALKS AND OUTDOOR ACTIVITIES CONSENT

Initials: _____

I grant permission for my child to participate in outdoor classroom, walks, and outdoor activities which may be scheduled in connection with the FBCC CDC, knowing that every safety precaution will be observed, but that the FBCC CDC cannot assume liability incurred during 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 FBCC CDC, outdoor classroom and off campus.

_____ _____

Signature of Parent/Legal Guardian Date

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# HANDBOOK AGREEMENTS

2025-2026

Name of Child: _____ Class Assignment: _____

NOTE: SECTION 22.1-4.3 OF THE CODE OF THE 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 OCURRING DURING THE SCHOOL OR DAY CARE ACTIVITIES.

APPROPRIATE PAPERWORK SUCH AS CUSTODY PAPERS SHALL BE ATTACHED IF PARENT IS NOT ALLOWED TO PICK UP THE CHILD OR CHILDREN.

The First Baptist Church of Clarendon Child Development Center agrees to notify the parent(s)/legal guardian(s) whenever the child becomes ill and the parent(s)/legal guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

The parent(s)/legal guardian(s) authorize the FBCC CDC to obtain immediate medical care if any emergency occurs when the parent(s)/legal guardian(s) cannot be located immediately. **

**If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s)/legal guardian(s) that states the objection and the reason of the objection.

I HAVE READ THE CURRENT PARENT HANDBOOK, FORMS IN THE ENROLLMENT PACKET, TUITION POLICIES, AND HEALTH REQUIREMENTS AND AGREE TO ADHERE TO ALL POLICIES OF THE FBCC CDC AS TERMS OF ENROLLMENT FOR MY CHILD. I UNDERSTAND THAT THEY ARE SUBJECT TO CHANGE UPON WRITTEN NOTICE BY THE CENTER.

_____ _____

Signature of Parent/Legal Guardian Date

Printed Name: _____

_____ _____

Signature of Parent/Legal Guardian Date

Printed Name: _____

# EMAIL REQUEST FORM

Please provide the best email addresses so that we may contact you as needed. This form will be kept in your child's file.

Name of Child: _____
Last Name First Name

Siblings (who attend the FBCC CDC) Names: _____

Please be sure to write legibly. Indicate the number zero by striking a line through (Ø).

Parent/Legal Guardian 1 Name: _____

Parent/Legal Guardian 1 Email: _____

Parent/Legal Guardian 2 Name: _____

Parent/Legal Guardian 2 Email _____

Parent/Legal Guardian 3 Name: _____

Parent/Legal Guardian 3 Email: _____

Parent/Legal Guardian 4 Name _____

Parent/Legal Guardian 4 Email: _____

Phone: 703-522-6477 Fax: 703-5227142

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