818 South King Street
Leesburg, VA 20175
Office#: 571-223-6736
Fax#: 571-223-6442
Website: www.leesburgopenarms.org

ALL-DAY PROGRAM

Projected Start Date: ____________________

☐ **All-Day Program** (Mon-Fri, 6:30am-6:30pm)

☐ **After-School Program** (K through 5th Grade)

☐ **Part-Time Care** (NOT available for Infants, 6 weeks through 18 months)

☐ M ☐ T ☐ W ☐ Th ☐ F

☐ **Loudoun County Drop in Student (LCPS drop in)** (Mon-Fri, 6:30am-6:30pm only on LCPS closings)

2018-19 FULL-DAY KINDERGARTEN ENRICHMENT

Full-Day Kindergarten (Mon-Fri, 8:00am-3:30pm) ☐

Extended Programs ☐ Before care (Mon-Fri 6:30-8:00am) ☐ After care (Mon-Fri 3:00-6:30pm) ☐ Before and After care (Mon-Fri 6:30am-6:30pm)

STUDENT INFORMATION

CHILD'S FULL NAME: ______________________________ NICKNAME: ____________________

AGE: ____________________ BIRTHDATE: ____________________ SEX (*circle one*): M F

STREET ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP: ______________

HOME PHONE: ____________________

CHILD LIVES WITH: ☐ MOTHER ☐ FATHER ☐ STEPMOTHER ☐ STEPFATHER ☐ GUARDIAN

WHO HAS CUSTODY OF CHILD, IF OTHER THAN PARENT: ____________________

FATHER/GUARDIAN

☐ MAKE PRIMARY SPONSOR

NAME: ______________________________ CELLPHONE: ____________________

WORK NAME: ______________________________ OCCUPATION: ____________________

WORK ADDRESS: ____

WORK PHONE: ______________________________ HOMEPHONE: ____________________

HOME ADDRESS: ☐ same as child **OR** ______________________________ Email: ____________________

MOTHER/GUARDIAN

☐ MAKE PRIMARY SPONSOR

NAME: ______________________________ CELL PHONE: ____________________

WORK NAME: ______________________________ OCCUPATION: ____________________

WORK ADDRESS: ____

WORK PHONE: ______________________________ HOME PHONE: ____________________

HOME ADDRESS: ☐ same as child **OR** ______________________________ Email: ____________________

MEDICAL INFORMATION

DOCTOR'S OFFICE: ________________________ DOCTOR'S NAME: _________________PHONE #: _________________________

ADDRESS: ____

DOES YOUR CHILD HAVE ALLERGIES? NO ☐ YES ☐

IF YES, PLEASE INITIAL HERE ______________GIVING PERMISSION FOR US TO POST ALLERGIES IN THE CLASSROOM.

SPECIAL DIETARY REQUIREMENTS: ____

CHRONIC PHYSICAL PROBLEMS/DEVELOPMENTAL INFORMATION/SPECIAL ACCOMMODATIONS:

____

DOES YOUR CHILD HAVE AN INDIVIDUALIZED EDUCATION PROGRAM? NO ☐ YES ☐

IF YES, DATE OF LAST IEP: _________________

(According to Virginia daycare licensing standards, we require a copy of your child's IEP each time it is updated/changed)

EMERGENCY CONTACT PERSONS

(Licensing requires we MUST have at least TWO LOCAL contacts, other than the parents)

NAME & RELATION:	CONTACT PHONE #:	CONTACT'S FULL HOME ADDRESS:
1.________________________	____________________	________________________________
2.________________________	____________________	________________________________

Listing a name as emergency contact person does NOT give permission for them to pick-up your child. Anyone other than a parent/guardian that is picking up your child MUST have current release paperwork (available at front desk) and will be verified by Open Arms staff.

PLEASE INDICATE YOUR FAMILY'S RELIGIOUS AFFILIATION: ______________________________________

WHERE DOES YOUR FAMILY CURRENTLY ATTEND CHURCH?: ______________________________________

HAS YOUR CHILD BEEN BAPTIZED? NO ☐ YES ☐

WOULD YOU LIKE INFORMATION ABOUT BAPTISM FOR YOUR CHILD? ☐ NO ☐ YES

CHILD'S PREVIOUS DAY CARE PROGRAM(S) AND SCHOOL(S) ATTENDED: ____________________________ N/A: ☐

IF CHILD ATTENDS THIS CENTER AND ANOTHER SCHOOL/PROGRAM, PLEASE GIVE NAME OF OTHER SCHOOL/PROGRAM:

SCHOOL/PROGRAM: ____GRADE:______________ N/A: ☐

SIGNATURE

____ ___________________________

PARENT/GUARDIAN DATE

- OFFICE USE ONLY- (Identity Verification)

Place of Birth	Date of Birth
Birth Certificate Number	Date Issued
Other Form of Proof	

Authorized Center Signature: ___________________________

Date Signed: _____________ Withdrawal Date:_____________

Reason for Withdrawal:_________________________________

- OFFICE USE ONLY -

Form Rcvd Date: __________ New ☐ Returning ☐ Sibling ☐

Amt Paid: $ ____________ Date Paid: _________

Cash ☐ Check ☐ Check #: _________ Gave Enrollment Packet ☐