



43115 Waxpool Road
 Ashburn VA 20148
 Office#: 703-729-9144
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 www.openarms-ccdc.org

ALL-DAY PROGRAM Desired Start Date: _____

All-Day Program (Mon-Fri, 6:30 am-6:30 pm) Part-Time All-Day Program (Intermediate Preschool– After School)

Kind-Ext/ After-School Program (Mon-Fri, after school-6:30 pm) M T W Th F

2018-2019 HALF-DAY PROGRAM AM Classes: 8:50-11:50 am or 9 am-12 pm

<p>Beginning Preschool (Must be 2 by March 31, 2018) ___ Tues & Thurs AM</p> <p>Intermediate Preschool (Must be 3 by October 31, 2018) ___ Tues & Thurs AM ___ Tues & Thurs Extended 9 am-2 pm ___ Mon/Wed/Fri AM</p> <p>Pre-Kindergarten (Must be 4 by October 31, 2018) ___ Mon/Wed/Fri AM ___ Mon/Wed/Fri Extended 9 am-2 pm ___ Tues-Fri AM ___ Mon-Fri Extended 850 am-150 pm</p>	- OFFICE USE ONLY - P2 _____ OE _____
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2018-2019 FULL-DAY KINDERGARTEN (Students must be 5 by October 31, 2018)

Full-Day Kindergarten (Mon-Fri, 8:30 am-3:30 pm) Extended Program Before School (Mon-Fri 6:30-8:30 am) and/or After School (Mon-Fri 3:30-6:30 pm)

STUDENT INFORMATION

CHILD'S FULL NAME: _____ NICKNAME: _____

AGE: _____ BIRTHDATE: _____ SEX (circle one): M F

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CHILD LIVES WITH: _____

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

FATHER/GUARDIAN

NAME: _____ CELL PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

FULL WORK ADDRESS: _____

WORK PHONE: _____ HOME PHONE: _____

FATHER'S EMAIL ADDRESS: _____

HOME ADDRESS: same as child **OR** _____

MOTHER/GUARDIAN

NAME: _____ CELL PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

FULL WORK ADDRESS: _____

WORK PHONE: _____ HOME PHONE: _____

MOTHER'S EMAIL ADDRESS: _____

HOME ADDRESS: same as child **OR** _____

MEDICAL INFORMATION

DOCTOR'S OFFICE: _____ DOCTOR'S NAME: _____ PHONE #: _____

MY CHILD HAS ALLERGIES and/or SENSITIVITIES. NO YES LIST: _____

MY CHILD REQUIRES EMERGENCY MEDICATION (EPI-PEN, INHALER ETC). NO YES LIST: _____

MY CHILD HAS SPECIAL DIETARY REQUIREMENTS (VEGETARIAN?). NO YES LIST: _____

MY CHILD REQUIRES MODIFICATIONS TO THE PROGRAM IN ORDER TO FULLY PARTICIPATE. NO YES
LIST: _____

MY CHILD HAS AN 'INDIVIDUALIZED EDUCATION PROGRAM' OR 'INDIVIDUALIZED FAMILY SERVICE PLAN.' NO YES
IF YES, DATE OF LAST IEP: _____ (VA licensing standards require Open Arms to keep a copy of your child's most recent IEP on file)

OTHER DEVELOPMENTAL INFORMATION: _____

EMERGENCY CONTACT PERSONS

Must have TWO local contacts, OTHER THAN parents

NAME & RELATION: CONTACT PHONE #: CONTACT'S FULL HOME ADDRESS:

1. _____

2. _____

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

RELIGIOUS AFFILIATION: _____

WHERE DOES YOUR FAMILY CURRENTLY ATTEND CHURCH?: _____

HAS YOUR CHILD BEEN BAPTIZED? NO YES WOULD YOU LIKE INFORMATION ABOUT BAPTISM? NO YES

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

N/A: CHILD ALSO ATTENDS ANOTHER SCHOOL/PROGRAM
SCHOOL/PROGRAM: _____ GRADE: _____

SIGNATURE

PARENT/GUARDIAN

DATE

- OFFICE USE ONLY -

(revised 6/21/2018)

Place of Birth	Date of Birth	Form Rcvd Date: _____	Amt Paid: \$ _____
Birth Certificate Number	Date Issued	Date Paid: _____	Check #: _____
Office Signature	Date Signed	CEF Given Date: _____	Due Date: _____
Other Form of Proof		<input type="checkbox"/> Reg Form PC Entry	<input type="checkbox"/> Waitlist Fee
		<input type="checkbox"/> Roster Entry	<input type="checkbox"/> Registration Fee
		<input type="checkbox"/> Calendar	<input type="checkbox"/> HD Deposit
		<input type="checkbox"/> CEF PC Entry	<input type="checkbox"/> Activity Fee
		<input type="checkbox"/> PC Schedule	<input type="checkbox"/> PC Billing
			<input type="checkbox"/> Sibling Discount

Start Date: _____ Schedule: M T W Th F Classroom: _____

Withdraw Date: _____ Reason for Withdraw: _____