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 Ashburn VA 20148  
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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

**2019-2020 HALF-DAY PROGRAM** AM Classes: 8:50-11:50 am or 9 am-12 pm

	<b>- OFFICE USE ONLY -</b> P2 _____ OE _____
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**Beginning Preschool** (Must be 2 by March 31, 2019)  
 \_\_\_ Tues & Thurs AM

**Intermediate Preschool** (Must be 3 by October 31, 2019)  
 \_\_\_ Tues & Thurs AM    \_\_\_ Mon/Wed/Fri AM

**Pre-Kindergarten** (Must be 4 by October 31, 2019)  
 \_\_\_ Mon/Wed/Fri AM    \_\_\_ Mon/Wed/Fri Extended 9 am-2 pm    \_\_\_ Tues-Fri AM    \_\_\_ Mon-Fri Extended 850 am-150 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 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 6/25/2019)

Place of Birth	Date of Birth	Form Rcvd Date: _____	Amt Paid: \$ _____
		Date Paid: _____	Check #: _____
Birth Certificate Number	Date Issued	CEF Given Date: _____	Due Date: _____
Office Signature	Date Signed	<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
Other Form of Proof			<input type="checkbox"/> Sibling Discount

Start Date: \_\_\_\_\_ Schedule: M T W Th F Classroom: \_\_\_\_\_

Withdraw Date: \_\_\_\_\_ Reason for Withdraw: \_\_\_\_\_