



DOWNTOWN HAMPTON CHILD DEVELOPMENT CENTER

60 Battle Road, Hampton, Virginia 23666 (757) 825-6200

| | | | |
|---|---------------------------------|-------------------|------------|
| Child | Nickname | Sex | Birth date |
| Address | | | Home Phone |
| Chronic physical Problems/Pertinent Development Information/Special Accommodations needed | | | |
| Does your child have an IEP or IFSP? Yes No | Primary language spoken in home | Ethnic Background | |

PARENTS/GUARDIAN

| | | |
|--|-------------------------------------|--------------------------|
| Father | Place Employed/ School Attending | Business Phone |
| Home Address | | Home Phone Cell Phone |
| Mother | Place Employed/ School Attending | Business Phone |
| Home Address | | Home Phone Cell Phone |
| Mother's Email Address | | Father's Email Address |
| Person(s) or Agency Having Legal Custody of Child* | | |
| Home Address | | Home Phone |
| Business Address | | Business phone |

EMERGENCY INFORMATION

| | | |
|--|---------|--|
| Allergies or Intolerance to Food, Medication etc. and Action to Take in an Emergency | | |
| Two People To Contact if Parents Cannot be Reached | Address | Home Phone Cell Phone Work Phone |
| 1. | | |
| 2. | Address | Home Phone Cell Phone Work Phone |
| Person(s) Authorized to Pick up Child | | |
| Person(s) NOT Authorized to Pick Up Child* | | |

***A copy of appropriate legal paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child**

Policy and Procedure Agreements

1. The Center agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange for the child to be picked up within thirty (30) minutes.
2. The parent/guardian authorizes the DHCDC to obtain medical care if an emergency occurs when the parent cannot be contacted immediately.
3. The parent/guardian gives authorization for the child to participate in the center's transportation and field trips: _____ YES _____ NO
4. I give DHCDC permission to photograph my child and reproduce my child's picture in connection with any Public Relations on behalf of our Center: _____ YES _____ NO
5. The parents/guardian agree to inform DHCDC within 24 hours or the next business day after a child or any member of the immediate family 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 have received a copy of the "Parent Policy Handbook" at orientation and understand the policies stated. **IT IS MY RESPONSIBILITY TO READ IT COMPLETELY!**

Signatures

Parent/Guardian Date

Administrator of Center Date

Additional Information

1. Previous Child Day Care Programs Attended: _____
2. Religious Restrictions: _____
3. How did you hear about DHCDC: _____

For Office Use Only

| | | |
|-----------------------|---------------------|-------------------------|
| Date Received: | Start Date: | End Date: |
| Orientation Date: | Site: Teacher: | Transportation: |
| Birth Certificate No: | Place of Birth: | Verified By: Date: |
| Other Form of Proof: | | Date Issued: |

Downtown Hampton Child Development Center

Child Emergency Contact and General Medical Information

Child's Name: _____ DOB: _____

Parent/Guardian (s) Name: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Allergies: _____

Health/Physical Problems: _____

Developmental Information/Special Accommodations needed: _____

Current Medications: _____

Family Doctor's Name: _____

- Complete Address: _____
- Phone Number: _____

Hospital Preference: _____

Health Insurance: _____

Emergency Contacts/Authorized Pick Up

1. Name: _____ Phone #1: _____ Phone #2: _____

2. Name: _____ Phone #1: _____ Phone #2: _____

Permission Slip

I, _____ give the DHCDC staff permission to apply
(Parent)

INSECT SPRAY or SUN SCREEN to my child, _____
(Circle one or both) (Child's Name)

Parent Signature

Date

Downtown Hampton Child Development Center

USDA ENROLLMENT FORM

_____ Age or DOB _____ is enrolled at:
Name of Child _____

Downtown Hampton Child Development Center
Name of Center _____

Address of Center _____

Starting on _____
(Month/Day/Year)

Normal Days in Child Care: **M T W TH F**

Normal Meals Expected to be served daily: **Breakfast** ___ **Lunch** ___ **PM Snack** ___

Please explain any unusual circumstances related to child's attendance at the center:

Signature: _____ **Date:** _____
(Parent or Guardian)

In accordance with Federal Law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice or TDD). USDA is an equal opportunity provider and employer.

Optional fields for parent or guardian:

Address: _____ Telephone: _____

For Center Use Only:

Participant Withdrew on _____
(Date)

Downtown Hampton Child Development Center

Financial Agreement-Effective 9/2/2008

Child's Name: _____

Date of Enrollment/Start Date: _____

Date of Dis-Enrollment/Last Date: _____

Registration Fee: \$50 **Date Paid:** _____ **Check/MO #:** _____

Supply Fee: \$50 **Date Paid:** _____ **Check/MO #:** _____

Weekly tuition rates for children 6 weeks through 2 years old are at a set rate:

6 weeks-12 months: \$180 **12-24 Months:** \$175 **24-36 Months:** \$160

Weekly tuition rates for children 3-5 years old are based upon a sliding-scale and are computed according to household income range. Please provide your most recent four paycheck stubs, a letter from employer with annual salary, or most recent W-2's. If no verification of household income is provided, you will have to pay at the top tier of scale.

Your weekly tuition is: \$ _____

Tuition payments are due on Friday for the upcoming week. Your child will not be able to attend the Center if payment is not made on time. Your child will be automatically dropped from the Center if your balance is two (2) weeks behind. If this does occur, you are responsible for paying all due fees.

Full weekly tuition is required for weeks including a holiday, such as July 4th.

All fees are to be paid in the form of Check, Money Order, Visa or MasterCard. No cash will be accepted except for late pick up fees.

The late pick up fee is \$10 per 15 minutes after 6PM.

I understand the Tuition policies and hereby agree to meet all above requirements.

Parent Signature

Date

Director Signature

Date