

A Child's Place at Hollin Hall

1500 Shenandoah Road, Alexandria, VA 22308

OFFICE: (703) 765-8811 FAX: (703) 765-6356 EMAIL: acphollinh@aol.com

PRESCHOOL REGISTRATION FORM 2010/2011

Name: _____ Nickname: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone: _____
Child's Social Security Number: _____ Sex (circle): Male Female

Parents: Single Married Separated Divorced

Mother's Name: _____ Father's Name: _____
Address: _____ Address: _____

Mother's Employer: _____ Father's Employer: _____
Mother's Work Phone: _____ Father's Work Phone: _____
Mother's Cell Phone: _____ Father's Cell Phone: _____
Mother's Email: _____ Father's Email: _____
Social Security No: _____ Social Security No: _____

Persons or Agencies Having Legal Custody:

Special Instructions Regarding Child Custody: _____

Persons Authorized to Pick Up Child: _____

Persons NOT Authorized to Pick Up Child: _____

Note: Appropriate documentation such as divorce decree will be attached if a parent is not authorized to pick up the child.

Emergency Information: Please complete the following information with complete address and phone numbers. In an emergency, persons listed below will be contacted in the event that a parent cannot be reached. **Contacts MUST BE LOCAL. Please indicate if phone number is home, work or cell.**

1. Name: _____ 2. Name: _____
Address: _____ Address: _____

Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

Physician Name: _____ Phone: _____
Last Tetanus Shot: _____ Allergies or Intolerance to food: _____
Actions to take in an Emergency Situation: _____

Nationality: _____ Language Spoken at Home: _____
Center/School Previously Attended: _____
Reason(s) for Leaving: _____
Any additional programs child is enrolled in: _____

How Did You Find A Child's Place?

Parent Referral (Name: _____) Money Mailer Yellow Pages
 Office for Children Signs Internet

Are there other children in your family? _____

Entrance Date: _____ Class: _____

A CHILD'S PLACE AT HOLLIN HALL
AGREEMENT OF ENROLLMENT

Enrollment: The parent(s)/guardian(s) of _____ submit herewith, non-refundable registration fee for the enrollment of their child into **A Child's Place at Hollin Hall**, 1500 Shenandoah Road, Alexandria, VA. The child is enrolled under the following circumstances:

1. **Tuition**: Parent(s) agree to pay tuition weekly in advance in accordance with the currently applicable tuition schedule and any subsequent modification(s), thereto; such modifications and Parent Handbook are hereby incorporated by reference into this Agreement. The parent(s) agree to pay court costs and 25% of the attorney's fees in the event of default in payment pursuant to the above terms. It is also agreed that parent(s) shall be entitled to no deduction for absence of child from the Center for any reason. **Tuition is due every week throughout the year regardless of holidays (Winter Break, Spring Break, etc.) or vacations.**
2. **Notice of Withdrawal**: Parent(s) agree to give **AT LEAST TWO FULL WEEKS** written notice to the Center before withdrawing their child. Regular tuition charges apply to this two-week period.
3. **Field Trips**: Unless parent(s) specifies otherwise in writing, it shall be agreed upon that the child has the parent(s) permission to go on all Center sponsored field trips. In case of an admission charge, advance notice will be sent to parent(s)
4. **Use of Pictures**: Parent(s) hereby gives permission for use of picture(s) or video/audio recording of their child participating in Center activities for Center publicity purposes.
5. **Disenrollment/Suspension**: Reasons for disenrollment or suspension include, but are not limited to: acts or threats of physical violence, unresolved differences with a parent or child, or non-payment of fees. The Director and Executive Administrator make the final decision.
6. **Care/Supervision**: The center shall exercise reasonable care in the supervision, education, and welfare of the child during the period the child is at the center. In a medical emergency, the Center shall attempt to contact the parent(s) and personal physician as soon as practicable, but it shall be free and hereby authorized to secure the most available medical assistance, with what appears to be the best interest of the child at the time of the emergency.
7. **Open Door Policy**: The Custodial parent(s) has the right to be admitted into the center at any time.
8. **Health Policy**: Parent(s) agrees that if the child's temperature rises above 100 degrees or shows signs of communicable illness while at the Center, the parent will make every effort to have the child picked up within the hour. We are required to take the children outside two times a day, weather permitting. If your child is too ill to go outside, your child is too ill to be at the school. Parent(s) agrees that they will inform the center within 24 hours or the next business day after if any member of the immediate household has developed any reportable communicable disease, except for life threatening diseases, which must be reported immediately.
9. **Non-discrimination policy**: A Child's Place, Inc. and Vivlow & Co. do not discriminate on the basis of sex, race, religion, or ethnic origin in admission, administration of its educational policies and the enforcement of enrollment policies.

Mother/Guardian Signature: _____ Date: _____
Father/Guardian Signature: _____ Date: _____
A Child's Place Representative: _____ Date: _____

Proof of Identification:

Child's Name _____ Child's Date of Birth: _____
Document: _____ Document #: _____
Document State/Country: _____ Information received by: _____

Withdrawal Date: _____ Effective: _____
Reason: _____

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Child's Emergency Medical Authorization

Name of Child: _____ Date of Birth: _____

Name of Parent (s) or Guardian: _____

Home Address: _____, _____, _____
Street City Zip

Mother's Work Address: _____ Phone#: _____

Father's Work Address: _____ Phone#: _____

The Parent(s)/ Guardian authorizes A Child's Place at Hollin Hall,
to provide immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic tests upon,
the use of surgery on, and/or the administration of drugs to his/ her child or ward if emergency occurs when he/she cannot be
located immediately. It is also understood that this agreement covers only when he/ she expects to be notified immediately. I
authorize emergency medical personnel to transport my child to a medical facility to receive immediate medical attention.

1.) I will be responsible for payment of medical care expenses _____
Please sign/initial above

2.) Medical Treatment costs are covered by:
a.) Blue Cross/ Blue Shield Policy Number: _____
b.) Medicaid Coverage Number: _____
c.) Other: Name of Insurance Company: _____
Policy Number: _____

3.) No Insurance: _____

Child's Physician or clinic attended: _____

Child's Allergies (if any): _____

Child's Doctor: _____ Phone#: _____

Family Doctor: _____ Phone#: _____

Medications child is taking: _____

Last Tetanus Shot: _____

Outstanding Medical History (i.e. diabetes, heart disease): _____

Signature: _____ Date: _____