



## STUDENT ENROLLMENT FORM

Enrollment Date \_\_\_\_\_  
 Withdrawal Date \_\_\_\_\_

**ADS 1 (TODDLERS - PRE-K)**  
 917 Princess Street  
 Alexandria, VA 22314

**ADS 2 (INFANTS)**  
 501 N. Henry Street  
 Alexandria, VA 22314

**ADS 3 (TODDLERS - PRE-K)**  
 1108 Oronoco Street  
 Alexandria, VA 22314

**MAILING ADDRESS:**  
 P.O. Box 26384  
 Alexandria, VA 22313

CHILD INFORMATION			
Last Name:	<b>Group:</b>		
First Name:	<input type="checkbox"/> Infant		
Nickname:	<input type="checkbox"/> Toddler		
Birthdate:	Male/Female	<input type="checkbox"/> Preschool	
PARENT INFORMATION			
<i>MOTHER INFORMATION</i>		<i>FATHER INFORMATION</i>	
Name:	Name:		
Date of Birth:	Date of Birth:		
Mother's Maiden Name:	Mother's Maiden Name:		
Address:		Address:	
City/State:	Zip:	City/State:	Zip:
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Email address:		Email address:	
EMPLOYER/SCHOOL INFORMATION		EMPLOYER/SCHOOL INFORMATION	
Name:		Name:	
Address:		Address:	
City/State:	Zip:	City/State:	Zip:
Work Phone:		Work Phone:	
MEDICAL INFORMATION			
Doctor:		Dentist:	
Location:		Location:	
Phone:		Phone:	
List any allergies and intolerance to foods, medications or other substances			
_____			
Action to be taken _____			
AUTHORIZATION FOR EMERGENCY MEDICAL CARE			
<i>(Please Note: This authorization must be <b>NOTARIZED</b>.)</i>			
If I cannot be contacted in an emergency situation, I authorize the center's staff to obtain emergency medical treatment for my child.			
Signature of Parent or Guardian _____		Date _____	
Subscribed and Sworn to before me this _____ day of _____, _____.			
Notary Public: _____		My Commission Expires: _____	
EMERGENCY CONTACT AND/OR PICK-UP AUTHORIZATION (OTHER THAN PARENTS):			
Emergency Contact # 1 Name:		Phone:	
Address:		Relationship to student:	
Emergency Contact # 2 Name:		Phone:	
Address:		Relationship to student:	

ADS 1: Tel: 703-837-0237    ADS1 Fax: 703-842-8851    ADS 2: Tel: 703-837-0238    ADS 3: Tel: 703-837-0099    ADS 3 Fax: 703-997-4277

# CHILD PROFILE

## FAMILY INFORMATION

Mother's Occupation \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Other family members (brothers, sisters, grandparents, etc.) living at home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

Other family members living in the community:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

## HEALTH INFORMATION

What communicable diseases has your child had? Measles (Big Red) Measles (3 day) Mumps  
Chicken Pox Whooping Cough Other \_\_\_\_\_

Does your child have any type of chronic physical condition? \_\_\_\_\_

Type of accommodations needed\*: \_\_\_\_\_

Does your child have any type of developmental or learning need? \_\_\_\_\_

Type of accommodations needed\*: \_\_\_\_\_

*\* If special accommodations are needed, a current copy of the child's IEP or ISP is required.*

## MEDICATIONS

Are any medications given regularly? (Please list medications and reasons)

Brand of infant formula (if applicable): \_\_\_\_\_

*\*Please note: It is American Day School's policy to feed infants on demand unless other written instructions are on file from the child's physician.*

## SPEECH (Please Check Where Applicable)

Describe your child's speech: Rapid \_\_\_ Moderate \_\_\_ Slow \_\_\_ Clear \_\_\_ Talks Constantly \_\_\_  
Seldom Speaks \_\_\_ Uses Many Words \_\_\_ Uses Few Words \_\_\_ Talks Only During Play \_\_\_

## TOILETING

Does your child have any special toileting needs? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

## SLEEP PATTERNS

What time does your child go to bed? \_\_\_\_\_ Awaken? \_\_\_\_\_ Does he/she walk, talk or cry out at night? \_\_\_\_\_

Does he/she take anything to bed with them? \_\_\_\_\_ What is his/her mood upon awakening? \_\_\_\_\_

Does he/she take naps? \_\_\_\_\_ Typical time/length of nap: \_\_\_\_\_

## INTERESTS

Has he/she had experience playing with other children? \_\_\_\_\_

With what age child does he/she prefer to play? \_\_\_\_\_

What are his/her favorite activities at home? \_\_\_\_\_

Does he/she like to: Be read to? \_\_\_\_\_ Listen to music? \_\_\_\_\_ Play outdoors? \_\_\_\_\_

Can he/she ride a tricycle? \_\_\_\_\_

Has he/she had experience with: Clay? \_\_\_ Scissors? \_\_\_ Easel Painting? \_\_\_ Blocks? \_\_\_ Puzzles? \_\_\_

Finger Painting? \_\_\_

**ADDITIONAL COMMENTS**

In what particular ways can we help your child this year?

Describe your child briefly (personality, abilities, etc.)

**SCHOOLING**

Please list any previous school and/or child care center enrollment:

Name of school/child care center \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

Name of school/child care center \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

Is your child attending another school concurrently with our program? \_\_\_\_\_

Name of School \_\_\_\_\_ Grade or Class Level \_\_\_\_\_

**FINANCIAL AGREEMENT**

I \_\_\_\_\_ (please print name), the parent/guardian of \_\_\_\_\_ agree to pay my child's tuition no later than Monday of the current week. If I have not paid by Tuesday of the current week, I understand that I will be charged a late fee. I also understand that if I do not pick my child up by the center's closing time, I will incur a charge of \$20.00 for any part of the first 15 minutes and \$1.00 per minute after 15 minutes. In the event that my child's tuition account becomes two weeks in arrears, I understand that my child care services with American Day School will be terminated. I also agree to pay all costs and expenses including, without limitation, court costs and reasonable attorney fees incurred by American Day School in connection with the collection of tuition and the enforcement of this agreement.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**HOLD HARMLESS AGREEMENT**

I \_\_\_\_\_ (please print name), the parent/guardian of \_\_\_\_\_ agree to release and hold harmless American Day School and its employees, from any accident or harm that may occur should I retain the services of any American Day School employee for the care of my child(ren) outside the child care center. I understand that American Day School does not condone or encourage its employees to babysit for parents of enrolled children outside of the child care center. If I retain the services of any American Day School employee in such capacity, American Day School has no responsibility and is held harmless from any incident which may occur.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**IDENTITY VERIFICATION**

**FOR OFFICE USE ONLY: Please do not fill this out.**

Place of Birth: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Birth Certificate Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Other Form of Proof: \_\_\_\_\_

Viewed by: \_\_\_\_\_ Date viewed: \_\_\_\_\_



# POLICIES

1. I understand that my child must not be left on school grounds without supervision. I agree to only release my child to a teacher before leaving my child.
2. I understand that all required forms must be completed and on file at the center before my child may attend.
3. I understand that no child may be released to anyone except parents/guardians without written permission. I understand that American Day School will release children to either parent unless a court order indicating sole custody is provided to the center Director. I agree to give to the center a list of all persons authorized to pick up my child.
4. I understand that no medication will be administered without written permission from parents.
5. I agree to support and reinforce the school’s rules and procedures that concern the health and safety of my child and other children.
6. I understand that the Director will notify me whenever my child becomes ill and I agree to pick-up my child or make arrangements to have my child picked up by an authorized individual within one hour of notification.
7. I understand that my child cannot attend the school if he/she has any illness that threatens the health of other children. I understand that Health Department regulations concerning periods of infection will be enforced. I understand that my child must be fever and symptom free for 24 hours before returning to school after an illness. I also understand that prescription medication must be administered to my child at home for 24 hours before he or she can return to school.
8. I understand that I am required to inform the center within 24 hours or the next business day if my child or any member of my immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.
9. I understand that child care services may be terminated for any of the following reasons:
  - My child’s tuition account becomes more than two weeks in arrears.
  - Failure to respond in a timely manner when contacted by the center to pick my child when he or she is sick.
  - Failure to adhere to the 24 hour illness recuperation period.
  - Failure to provide the center with up-to-date emergency contact information for my child.
  - American Day School does not receive parental support and help if my child is found to have a learning or behavioral problem. This includes failure to attend parent conferences and to follow through with medical and/or educational specialists.
  - My child’s behavior pattern threatens his or her own health and safety or threatens the health and safety of other children and staff.
  - Parents/guardians are no longer supportive of American Day School’s program and Philosophy and become negative and uncooperative in their actions and opinion which may undermine the operation of the school.
  - Parents who are repeatedly late will be asked to make other child care arrangements.

**PLEASE READ AND SIGN:**

*I have read the policies in the American Day School Parent Handbook and understand their application to me and my child.*

Mother/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_  
(mm/dd/yyyy)

Father/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_  
(mm/dd/yyyy)

Director’s Signature \_\_\_\_\_

Date \_\_\_\_\_  
(mm/dd/yyyy)