Revised 09/17/2019

ALIVE! CHILD DEVELOPMENT CENTER APPLICATION

Application Date:_____ Start Date:_____

******PLEASE **PRINT** ALL INFORMATION******

CHILD'S INFORMATION:

Child's **N**ame_____ Nickname_____
Date of Birth (month/day/year)_____Gender __Male __Female

Age verified by (check one): (**OFFICE PERSONNEL ONLY**)
___certified copy of birth certificate; number:_____ state:____
___notification of birth: hospital, physician, midwife record
___Baptismal record
Name of ALIVE staff making verification_____ Date_____

Child's Ethnicity: ___African, name of country
___Asian/Pacific-Islander
___Black (African-American)
___Hispanic/Latino
___Middle Eastern
___American Indian
___Caucasian
___Other:_____

Child lives with: ___Both parents
___Mother
___Father
___Mother & Stepfather
___Father & Stepmother
___Other(please explain):_____
___Shared Custody – Please explain arrangement:
_____
Please note that a copy of any court ordered visitation or restraining order documentation must be provided to ALIVE! CDC *before* the child begins attending

Languages Spoken at home_____
Child's main language_____
At the birth of this child: Mother's age_____ Father's age_____

Household Size: # of persons living in the same house/apt as child:_____
Child's drug allergies:_____
(If yes, how does body react?)
Child's food allergies:_____
(If yes, how does body react?)
Medical Dietary
Restrictions:_____
(Alive must have a physician's statement on file *before* restriction can be applied)
Religious Dietary Restrictions:_____
Child's chronic physical problems:_____
(Are these identified on *School Entrance Form*?)
Child's regular medication needs:_____
(ALIVE must have written instructions from child's medical provider *before* Any Rx medication can be given).
Physician's Name:_____ Phone:_____
Physician's Address:_____
Child's Health Insurance:
Name of Company/Health Policy:_____
Insurance I.D. #:_____Medicaid #:_____

PERSONS AUTHORIZED TO PICK CHILD UP FROM ALIVE! CDC (Persons other than parents living within 30 minutes of ALIVE! CDC):

1. Name:_____ Relationship to child:_____

   Address:_____

   Home #:_____Work #:_____Cell #:_____

2. Name:_____ Relationship to child:_____

   Address:_____

   Home #:_____Work #:_____Cell #:_____

3. Name:_____ Relationship to child:_____

   Address:_____

   Home #:_____Work #:_____Cell #:_____

MOTHER"S INFORMATION:

Name:_____ Date of Birth:_____

Address:_____
Street Apt# City Zip Code

Home Phone:_____ Cell Phone:_____

E-mail address:_____

Place of Employment:_____

Address of Employer:_____
Street City Zip Code

Work Phone:_____ Work E-mail address:_____

Mother is currently a full-time student attending classes at:_____

_____

Highest level of education completed:_____

Mother's Ethnicity:

___African, name of country:_____
___Asian/Pacific Islander
___Black African-American
___Hispanic/Latino

___Middle Eastern
___Caucasian
___American Indian___
___Other:_____

Mother's Marital Status:

___Single
___Married
___Legally Separated
___Divorced
___Widowed

Mother's Gross Income:

$_____per:
___week
___every other week
___Bi-monthly
___Monthly

Income verified by:
___3 most recent pay stubs
___W-2 from year____

Child Support Received:

$_____per
___Week
___Month
___Other

Is Child Support Court-ordered? _____ Is Child Support by mutual agreement?_____
(Documentation provided?_____

FATHER'S INFORMATION:

Name:_____ Date of Birth:_____

Address:_____
Street Apt# City Zip Code

Home Phone:_____ Cell Phone:_____

E-mail address:_____

Place of Employment:_____

Address of Employer:_____
Street City Zip Code

Work Phone:_____ Work E-mail address:_____

Mother is currently a full-time student attending classes at:_____

_____

Highest level of education completed:_____

Father's Ethnicity:

___African, name of country:_____
___Asian/Pacific Islander
___Black, African American
___Hispanic/Latino
___Middle Eastern
___Caucasian
___American Indian
___Other:_____

Father's Marital Status:

___Single
___Married
___Legally Separated
___Divorced
___Widower

Father's Income:

$_____per:
___week
___every other week
___bi-monthly
___monthly

Income verified by:
___3 most recent pay stubs
___W-2 from year____

Child Support Received:

$_____per:
___week
___month
___other:_____

Is Child Support Court-Ordered?____
Is Child Support By Mutual Agreement?___

Total Annual Income from all sources: $_____

I HAVE RECEIVED THE FOLLOWING: (CHECK ALL THAT APPLY)

____Parent Handbook
____Orientation to Center
____Trial Visit of my child to program
____School's Annual Calendar
____"Building For The Future" Information from USDA

I CERTIFY THAT ALL OF THE ABOVE INFORMATION I HAVE PROVIDED REGARDING MY FINANCIAL STATUS AND THE COMPOSITION OF MY HOUSEHOLD IS TRUE AND ACCURATE. I UNDERSTAND THAT I MUST NOTIFY THE ALIVE! CDC WITHIN 10 DAYS IF ANY OF MY FINANCIAL OR HOUSEHOLD INFORMATION CHANGES. I FURTHER UNDERSTAND THAT FAILURE TO INFORM THE CENTER OF ANY CHANGES IN STATUS WILL JEPORDIZE MY FAMILY'S ELIGIBILITY TO PARTICIPATE IN ALIVE! CDC'S INCOME-BASED TUITION PROGRAM. FAILURE TO PAY FEES AS REQUIRED WILL RESULT IN MY CHILD'S SUSPENSION, AND FAILURE TO PAY OVERDUE TUITION FEES AS REQUIRED WILL RESULT IN MY CHILD'S DISENROLLMENT FROM THE ALIVE! CDC'S PROGRAM.

_____

Parent/Guardian Signature/Date

EMERGENCY AUTHORIZATION

I _____give permission to ALIVE!
(Parent's Name)
Child Development Center to use whatever emergency measures are judged necessary for the care and protection of my child_____
while in ALIVE!s care. (Child's name)

In case of a medical emergency, I understand that these measures may include, but are not limited to the following" 1) attempt to contact the parent/guardian; 2) attempt to contact child's physician; and/or 3) attempt to contact the parent through any of the persons listed as emergency contacts. I further understand that if I or my child's physician cannot be reached, the Center may do any of the following: 1) call another physician; 2) call for an ambulance; and/or allow the child, accompanied by a staff person, to be transported to an appropriate medical facility for treatment if the local emergency resource deems it necessary. I also understand that any expenses incurred will be paid by my family. Finally, it is understood that in some medical situations staff will need to contact the local emergency resource before the parent, the child's physician, and/or any other adult acting on the parent's behalf. I authorize the Center to obtain immediate medical care in case of an emergency if the parent(s) cannot be located at once.

Parent/Guardian Signature_____ Date_____

EMERGENCY CONTACTS:

Every attempt will be made to contact the parent(s) in case of an emergency. Timely notification depends on the accuracy of the contact information provided by the parent. In the event that ALIVE! staff are unable to immediately reach the parent(s), the following responsible persons will be contacted in the order given:
(AT LEAST **TWO** **NAMES AND NUMBERS ARE REQUIRED)**

1. Name_____ Relationship to Child_____

   Address:_____

   Day #:_____Evening #:_____Cell #:_____

2. Name_____ Relationship to Child_____

   Address:_____

   Day #:_____Evening #:_____Cell #:_____

ALIVE! CDC PERMISSIONS:

I_____ parent/guardian of
(Please print parent name)
_____give permission to ALIVE! CDC for:
(Please print child name)

Please initial those items agreed to:

___my child to be **photographed** or **videotaped** by Center staff. These photos and/or videos may be used outside the school in local news media to promote ALIVE!

___**sharing information** about my child, such as assessment and/or screening scores, with **Alexandria Public Schools,** to better meet my child's needs and assist in making a successful transition to kindergarten.

___to **obtain information from Alexandria City Public Schools** to assist ALIVE! in determining the impact of our program on your child's success in kindergarten.

___**requesting information from the Department of Community and Human Services,** regarding subsidized child care, such as: application processing dates, approval/denial information, family size/income.

___**consulting with Alexandria's Early Childhood Prevention Team** regarding my child and allowing observations of my child in class as needed.

___**screenings of my child for hearing, vision, and dental health.**

___**conducting developmental screening of my child.**

___for taking my child on **neighborhood walks** with the class, where no streets are crossed and the walk is no farther than 2 blocks from the Center.

I have read and understand the above information and agree to all those items I have initialed.

Parent Signature/Date

ALIVE! CDC REQUIREMENTS

I have read each of the following requirements and understand that my child's participation in the ALIVE! CDC program requires that I comply with each of these requirements. I further understand that my failure to do so will result in my child's suspension from the program, and/or termination, at the discretion of the Director.

(Place your initials beside each requirement)

____At the time of enrollment, I must provide the ***School Entrance Form***, completed by my child's medical provider within the past 6 months.

____When I am informed of my child **becoming ill while at the Center**, I must arrange to have my child picked up within one hour of my being notified.

____My child MUST be **symptom-free for a full 24 hours before** returning to the Center; certain symptoms/conditions will require a notice from your child's medical provider before he/she can return.

____I will inform the CDC within 24 hours or on the next business day if my child or any other member of my immediate household has developed any reportable communicable disease as defined by the State Board of Health.

____I MUST participate in each of the following:

___Individual Orientation (new student)
___Back-To-School Night
___Parent Circle Meetings (75% of total)
___Fall Parent-Teacher Conference
___Spring Parent-Teacher Conference

____I understand that my family's participation in the Family Support Project is a requirement for enrollment in the ALIVE! CDC. This participation includes **two home visits** during the year. The first of these must occur within 30 days of enrollment (for new students) or during the months of July through November (for the Fall home visit). Spring home visits must occur between the months of January and June.

The Family Support Worker will provide you with a written notice of your visit approximately one week in advance.

____I MUST notify the ALIVE! CDC **IMMEDIATELY** of **any changes to my child's emergency information,** including phone numbers, address, parent's employer).

____I understand that my child may **NOT be at ALIVE! CDC for more than the hours authorized per day;** it is my parental responsibility to arrange for my child's care in excess of the authorized hours with another provider if/when such a need arises.

___My child must arrive at the CDC no later than 9:00 am each day, unless she/he has a medical appointment; I must inform staff of this appointment beforehand, if possible; **if my child arrives late three** times**, he/she may be disenrolled,** at the discretion of the Director.

___I must pay a **late pick-up fee** if my child is picked up after **5:45 p.m.** (as determined by the Center's office clock); the fees are as follows: $15.00 for 1-5 minutes late and $1.00 per minute after that; late pick-up fees are due no later than the following morning; I understand that if my child has not been picked up by 7:00 p.m., **Child Protective Services will be called. If my child is picked up late 3 times, or if I fail to pay the late fee as required, my child may be disenrolled,** at the discretion of the Director.

____I MUST **sign my child in correctly** every morning on the classroom's sign-in sheet, and ensure that he/she is handed over to a staff member.

___I MUST check my child's cubby each day at pick –up; it is my responsibility (or the responsibility of the person picking up my child) to **take all items from my child's cubby daily.**

___I MUST **sign my child out correctly** every evening; only pre-authorized persons will be allowed to pick up my child and will be asked for photo ID; I am responsible for my child as soon as I enter the ALIVE! CDC premises.

___If the Alexandria City Public Schools are **closed due to severe weather or emergency,** the ALIVE! CDC is also closed.

___If the Alexandria City Public Schools are **delayed in opening due to severe weather or emergency, the ALIVE! CDC will open at 10:00 a.m., regardless of the opening times for the City Schools.**

___If I am called during the day and told that **ALIVE! CDC is closing early due to severe weather or emergency**, I MUST pick my child up by the time designated by ALIVE! (usually within 1 hour of when the decision to close is made). Late fees WILL apply beginning at the designated time.

____ **Medications will be administered only by a staff member currently certified to do so;** medications must be in the original container with a current order from the child's medical provider; parent must complete the required form; all medication must be stored in a locked box either in the Director's Office or in the school's refrigerator.

____I and/or other adults either dropping off or picking up my child must abide by Alive!'s "no cell phone usage" policy.

____I and/or other adults dropping off or picking up my child must abide by Alive!'s "no food/snacks/candy/gum or drinks (except for bottle water)" policy.

____Full payment of tuition is due **even if my child is absent due to illness or other reason, or if the school is closed due to severe weather or emergency.**

____Tuition is due on MONDAYS, at the START of each week or month (or, at the START of the two-week period, if paying every two weeks); tuition is LATE after the Close Of Business Wednesday of that week **; I will receive ONE notice of overdue tuition, placed in my child's cubby; if I fail to pay the overdue amount as required, my child will be suspended, and my account will be referred to a collection agent; if I fail to pay my overdue tuition fees within the designated time, my child will be terminated.**

____My **work** schedule is as follows:
Monday from_____ until_____
Tuesday from_____ until_____
Wednesday from_____ until_____
Thursday from_____ until_____
Friday from _____until_____

_____My pay stubs reflect this schedule **OR** I have provided an official copy of my work schedule; if my work schedule is used to determine the hours of authorized care for my child, I understand that I must submit, bi-weekly (every OTHER week), to the CDC office, a copy of my current work schedule.

_____Per my work schedule/pay records, my child's authorized hours of care, as of_____ are from _____ a.m. until _____ p.m. _____through_____.

___I understand that my fee is as follows:

$_____per _____

The daily fee for my child (when absent for a non-creditable reason) is $_____per day.

Parent/Guardian Signature/Date

Parent's Printed Name

Revised 09/17/2019

CHILD & FAMILY HISTORY

Child's Name_____ Today's Date_____

In order to ensure a smooth transition for your child to the ALIVE! Child Development Center program, we ask that you complete this form. Your child's care is a responsibility that we share. Together, we can provide a developmentally appropriate early care and educational experience that will prepare your child for success in the future.
All information contained in this document is kept confidential and requires your permission if it is to be shared with anyone other than the following ALIVE! CDC staff: the Director, the Family Support Worker, and your child's teachers (lead and assistant).
Some questions may not apply to your child at this time; please leave them blank. You are NOT required to answer any question that makes you uncomfortable.

What are your expectations for your child while he/she attends the ALIVE! CDC?

In what particular way can we help your child and/or family?

Brothers and Sisters:

Name_____ Birth Date_____ Living at home? Yes No

Name_____ Birth Date_____ Living at home? Yes No

Name_____ Birth Date_____ Living at home? Yes No

Name_____ Birth Date_____ Living at home? Yes No

Other Members of Household:

Name_____Relationship_____Age____

Name_____Relationship_____Age____

Name_____Relationship_____Age____

What particular cultural practices would you like us to know about?

_____

_____

_____

_____

What holidays does your family observe? Please check all that apply:

_____Christmas	_____Valentine's Day	_____Thanksgiving
_____Easter	_____St. Patrick's Day	_____New Year's
_____Ramadan	_____Halloween	_____Al-Hijira
_____Milad-Un-Nabi	_____Eid-Ul-Adha	_____Ashura
_____Rosh HaShana	_____Yom Kippur	_____Sukkot
_____Chanukkah	_____Purim	_____Orthodox Christmas
_____Pascha	_____Martin Luther King, Jr. Day	_____Juneteenth
_____Kwanzaa	_____Mardi Gras	_____Cinco de Mayo
_____4th of July	_____Mexican Independence Day	_____Diwali
_____Dia de los Muertos		_____Las Posadas

_____Other: (Please list):_____

Would you be willing to share with us any special foods, crafts, games, music, dance, or other practices that are special to your family? If so, what are they?

_____

_____

_____

_____

_____

Do you have any religious practices that you would like us to be aware of?

Would you be interested in volunteering in our program? In what way?

CHILD"S DEVELOPMENTAL HISTORY

Prenatal:

Mother received prenatal care from_____ month of pregnancy
Weight gain during pregnancy_____lbs.
Use of alcohol: none___ occasional___ daily____
Use of tobacco: none___ occasional___ daily____
Use of drugs: none____ occasional___ daily____
Specific illnesses of mother_____
Accidents during pregnancy_____
Medications taken during pregnancy_____
Movement of baby first felt at_____ months

Procedures during pregnancy:
Amniocentesis____ Ultrasound____ Diagnostic tests_____

Duration of pregnancy:
____Full term (37-40weeks) ____Premature ____Post Mature

Delivery:

Where child was born_____
Length of Labor_____ Was labor induced?_____
Type of Delivery: ___vaginal ___caesarean section
How did membranes rupture: ____spontaneously ___ artifically
Were any of the following present:

____meconium staining	____use of forceps
____atonicity ("floppy")	____prolapsed cord
____placenta previa	____anesthesia
____episotomy	____medication

Other:_____

Condition at Delivery:

APGAR score: ____one minute ____five minute
Weight: ___ lbs ___ oz Length: ____inches Head circumference:____ inches
Did child breathe spontaneously?_____
Was suction used?_____ Was oxygen administered?_____
Was child placed in isolette? _____For how long?_____
Was child transferred to another hospital?_____
Was child placed in intensive care? _____For how long?_____
Child was discharged from hospital _____days after birth

Neonatal:
During the first 30 days after birth, were any of the following used:

Oxygen_____ Phototherapy_____ Exchange transfusion_____
Intravenous feedings_____ Gavage Feedings_____ Surgery_____

During the first 30 days were any of the following present:

Cyanosis____ Jaundice____ Paralysis_____ Convulsions_____

Nutrition and Eating:

Child was : ____breast-fed until age_____ ____bottle-fed until age_____
My child began to feed him/herself at age:_____
Child currently eats using: ____spoon ____fork ____hands
My child takes a vitamin mineral supplement daily:_____
Child is what type of eater? ____good ____picky ____slow ____fast
My child's favorite foods include:_____
My child dislikes/refuses to eat:_____
My child has the following food allergies:_____
(Has this been documented on the School Entrance Form?)
My child currently is: ___Underweight ____Overweight ____Normal weight

Sleeping:

Age at which child slept through the night_____
Age at which child moved from crib to bed_____
Bedtime is at_____ p.m. Wake-up time is at_____ a.m.
Does child share a bedroom?_____ With whom?_____
Child's mood on waking is_____
Does child take a nap?_____ From _____until_____
Does child wet the bed?_____

Toileting:

Age when child completed toilet-training_____
Does child indicate when he/she needs to use toilet?_____
How does he/she communicate this?_____
What word does child use for urination?_____
for a bowel movement?_____
Does child have toileting accidents? _____How often?_____
Can child fully manage his/her clothing when toileting?_____
Needs help with_____
Does child wash hands independently?_____

Speech & Language:

At what age did the child:
Speak first word_____(da-da) Speak in 2-word phrases (mama, up!)_____
Speak in 3-word phrases_____(Me go park)
Speak in complete sentences_____(I want a cookie now.)

Child has a speaking vocabulary of at least:
____< 50 words ____50 words ____100 words ____200 words

Is your child's speech easily understood by unfamiliar persons?_____

Child's spoken language includes:
____nouns (mom, boy, dog) ____verbs (go, eat, play)
____adjectives (red, big, round) ____pronouns (I, me, you)

Child can follow a :

____ 1-step direction ("pick up the cup")
____2-step direction (Give me the book and sit down)
____3-step direction (Close the door, put the book on the table, and sit on the chair)

Are there any special words that would help us communicate with your child?

Do you have any concerns regarding your child's speech and language that you want us to know about at this time?_____

Academic Readiness:

Has your child had experience with: (Check all that apply)

____using playdough/clay
____cutting with scissors
____building with blocks
____looking at picture books
____singing songs/rhymes
____learning ABCs
____drawing with crayons/markers
____using playground equipment
____identifying shapes
____identifying colors
____finger painting
____easel painting
____sand or water play
____going to the library
____retelling familiar stories
____counting
____writing with a pencil
____pretend play with housekeeping materials, dolls, puppets, cars

Do you have any concern regarding your child's academic readiness that you want us to know about at this time?_____
If yes, please describe:_____

Movement & Sensorimotor Functioning:

Age at which your child first:
Rolled Over____ Sat alone_____ Crawled_____ Walked_____

Is child: ____Left-handed ____Right-handed ____Uses both hands

Can child do the following: (Check all that apply)

____walk backwards ____hop on 1 foot ____gallop ____skip
____jump forward ____throw large ball ____catch large ball
____run ____kick large ball forward ____balance on 1 foot
____climb up stairs, alternating feet ____climb downstairs, alternating feet

Does child react normally to pain?_____
Does child enjoy being touched, hugged, held?_____
Does child dislike wearing clothes?_____
Does child dislike wearing shoes?_____
Does child bump into doorways and/or objects?_____
Does child become frustrated when playing with a new toy?_____
Does child avoid eating foods with new textures?_____
Does child often choke or gag on food or liquid?_____
Does child get carsick (or airsick?)_____
Does child avoid swinging or riding on merry-go-round?_____
Does child swing or spin for long periods of time without becoming dizzy?_____
Does child rock or jiggle parts of his/her body while sitting or when doing other activities?_____
Does child avoid or become very distressed in reaction to loud noises, bright lights or other unusual stimuli?_____
Does child laugh or cry at inappropriate times?_____

Do you have any concerns about your child's sensory development or movement at this time that you would like us to know about?

Social-Emotional Relations:

Has child had previous experience in group care?_____
Name/Location of previous provider: _____for how long_____
How often does child play with other children:_____
Child mostly plays with: ____girls ____boys ____both
Child's playmates are mostly: ____older ____younger ____same age

By nature, my child is:

____friendly ____aggressive ____shy ____withdrawn

At home, my child's play is usually: (check all that apply)

____active
____quiet
____solitary (alone)
____cooperative (with other children)
____cooperative
____self-initiated
____adult-initiated
____peer-initiated (joins in what others do)
____rough
____gentle

When inside, what toys does your child prefer to play with?_____

_____

When outside, what activities does your child prefer?_____

_____

How does child get along with brothers and sisters?_____
How does child get along with other adults?_____
How does your child react to new people in his/her life?_____
Does your child know any other children at ALIVE! CDC?_____
How well will your child adjust to preschool?_____
What makes your child angry or upset?_____
What does child typically do when upset or angry?_____
Is child emotionally sensitive to any particular thing?_____
What method of behavior management do you use?

_____

_____

Who does most of the disciplining at home?_____

Is your child frightened of any of the following? (please check all that apply)

____animals:_____
____storms
____darkness
____loud noises
____men
____women
____Other:_____

Do you have any concerns about your child's social relationships that we should be aware of?

Health History:

What past illnesses has your child had? (Check all that apply)

____Chicken Pox	____Measles
____Mumps	____Ear Infections
____Pneumonia	____Asthma
____Influenza	____Other:_____

Does your child have frequent:

____colds	____stomach aches	____fevers
____rashes	____sore throats	____toothaches

Does your child vomit easily?_____
Has your child had any serious accidents, such as falls or auto accidents?_____
Has your child been hospitalized? _____When _____For what_____

Has your child been seen by a dentist?_____ If so, when:_____
Name of dentist:_____ Reason_____

Has your child's vision been tested?_____ If so, when:_____
Name of vision specialist_____ Results:_____

Has your child's hearing been tested?____ If so, when:_____
Name of hearing specialist:_____ Results:_____

Has your child received a developmental screening? _____If so, when:_____
Screened by:_____ Results:_____

Do you have any concerns about your child's health that you would like us to know about at this time?_____

ANY ADDITIONAL COMMENTS:

Parent/Guardian Signature/Date