LITTLE RIVER DAY SCHOOL

CHILD REGISTRATION FORM

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade or Class Level

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address		Home Phone
Parent	Place Employed	Work Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached 1.	Address 1.	Phone 1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or day care activities.

INFECTION CONTROL POLICY

Please help us in our effort to keep your children healthy by cooperating in the following ways:

1. If your child has been exposed to any of the following diseases listed below, we ask that parents notify us of the exposure: **Covid-19, Chickenpox, Pink eye, Fifth disease, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Norovirus, Head lice, Ringworms of the body, Rubella, Scabies, Pertussis and Streptococcal diseases.**

2. LRDS staff will contact you to pick up the child immediately if your child/ children has symptoms listed below. Please help us protect ALL our children by responding promptly. If your child has any of the following symptoms at home, we ask that you keep him/her out of school until the symptoms are gone or until the physician says it is okay to return to the Center.

The symptoms include **Fever greater than 100F, severe coughing, high pitched croupy or whooping sounds after coughing, difficult or rapid breathing, yellowish skins or eyes, pink eye tears, redness of eyelid lining followed by swelling and discharge of pus, unusual spot of rashes, sore throats or trouble swallowing, infected skin patches, crusty bright yellow, dry or gummy areas of skin possibly accompanied by fever, unusually dark, tea colored urine especially after the fever, grey or white stool, headache and stiff neck, recurrent vomiting or diarrhea, severe itching of body or scalp or scratching of scalp.**

3. If your child has symptoms such as **A. less active less than usual, B. cries more than usual and appears cranky and C. just seems unwell**, please inform the child's teacher so the child can be watched carefully for the development of any symptom. It is imperative that we all work together to keep all our children as healthy and happy as possible. We thank you for cooperating with us.

PARENT AGREEMENT

I have read and understand the attached infection control policies, and I agree to abide by them for the protection of my child as well as other children and staff at Little River Day School.

The Infection Control Policy and procedures have been presented and explained to the parent by

_____ (staff name) on _____ (date).

Signature of parent: _____ Date _____

Signature of staff: _____ Date _____

EMERGENCY MEDICAL AUTHORIZATION

This form is to be KEPT by the child care operator and is to be taken to the doctor or treatment facility in case of emergency.

Child's Name	**Date of Birth**
Home Address	
Mom's Phone #	**Dad's Phone #**

If my child becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or health provider to give the emergency medical treatment required:

Hospital Name:
Hospital Address:

OR

Health Provider Name	**Telephone number**
Address	

I give permission to Little River Day School, located at 5510 Cherokee Ave Alexandria, VA 22312 to obtain immediate care and consent to the hospitalization of the performance of diagnostic test upon, the use of surgery on and or the administration of drugs to my child. It is also understood that this agreement covers only situations, which are true emergencies and only when I cannot be reached. I accept responsibilities for any necessary expense incurred in the medical treatment of my child.

Do you have a medical insurance for your child? YES_____ NO _____

If Yes, please fill out the information below:

Health Insurance Company	**Policy Number**
Name of Policy Holder	**Relationship to Child**
State	**Coverage**

Notes on child's known allergies or health condition if he/she has any:

_____

_____

_____

Parent's Signature _____ Date _____

AGREEMENTS

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain emergency medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) ***Date***

_____ _____

Administrator of Center ***Date***

First Date of Attendance: _____ Last Date of Attendance: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth	**Birth Date**	**Birth Certificate Number**	**Date Issued**
Other Form of Proof		**Date Documentation Viewed**	**Person Viewing Documentation**

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

_____

Date

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section § 22.1-289.049 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction, or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means..