

*Horizons Unlimited Early Learning Center*  
221 Marston Ave / PO Box 231  
Urbanna, VA 23175  
804.758.0711

## Child Application Form

Please complete the application by filling out the form completely.  
All fields must be filled out completely in order to process registration.  
All addresses **must** include physical (911) address.

Child's full name \_\_\_\_\_ Birthday: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ \*If B/A – name of school \_\_\_\_\_

- Grade: \_\_\_\_\_

Desired Start Date: \_\_\_\_\_ Previous Daycare Attended: \_\_\_\_\_

Child Lives with Mother  Father  Both Parents  Guardian

Parent / Guardian Information:

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Phone: Home- \_\_\_\_\_ Cell- \_\_\_\_\_ Phone: Home- \_\_\_\_\_ Cell- \_\_\_\_\_

Employer: Name: \_\_\_\_\_ Employer: Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: Married  Single  Divorced

Person with legal custody: \_\_\_\_\_

\*attach pertinent paperwork such as a Court Order if a parent is not permitted to pick up the child.

Parent / Guardian email address: \_\_\_\_\_

When submitting your student application, please include:

- 1) Registration fee
- 2) A copy of: Birth Certificate, Immunization Record, Most Recent Physical

If you have any questions please call 804.758.0711

# Emergency Contact Information

## *Emergency Contacts / Authorized Pick-Up*

The following people are **authorized to pick up my child** and **may be contacted in an emergency** or illness in the event I cannot be reached. Please list persons within a 20 mile radius. PERSONS LISTED MUST NOT BE PERSON WITH WHOM CHILD RESIDES. \*Required Field

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_  
\_\_\_\_\_

\*Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_  
\_\_\_\_\_

\*Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_  
\_\_\_\_\_

\*Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_  
\_\_\_\_\_

\*Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

## *Persons **NOT** Authorized for Pick-Up*

**Please note:** Horizons Unlimited **must** have a copy of the legal custody order in order to detain pick up from a parent.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Cell Work

Relationship to child: \_\_\_\_\_

## **Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed:**

## **Allergies or Intolerance to Food, Medication, etc.:**

**Child's Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Child's Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

## Agreements

1. Payments are to be made on Monday for that week of childcare service by close of business. **A late fee of \$15.00 will be charged daily** if payment is not received by noon on Tuesday of the same week. If full payment and late charges are not paid in full by Friday of the same week, the child will not be allowed entrance to care on Monday of the following week.

2. **Fees are considered to be a flat rate.** (Full weekly fees will be due at the beginning of the week regardless of your child's attendance.)

3. **Flat rates also apply to all holiday weeks and your vacations.** A list of all closed holidays will be provided in your "Parent's Handbook."

4. The Center requires a two-week paid notice should you choose to withdraw your child(ren).

Age of Child: \_\_\_\_\_ Weekly Rate for Child: \_\_\_\_\_

5. Horizons Unlimited E.L.C. agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible if so requested by the Center. Children must be symptom free for 24 hours without medication to return to school.

6. The parent agrees to inform the center within 24 hours or the next business day after his child or any member of the 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.

7. The parent/guardian authorize Horizons Unlimited E.L.C. to obtain immediate medical care if any emergency occurs when the parent/guardian cannot be located immediately.

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Starting Date

\_\_\_\_\_  
Leaving Date

### OFFICE USE ONLY IDENTITY VERIFICATION

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

<b>Place of Birth</b>	<b>Birth Date</b>	<b>Birth Certificate Number</b>	<b>Date Issued</b>
<b>Other Form of Proof</b>		<b>Date Documentation Viewed</b>	<b>Person Viewing Documentation</b>

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