The Child & Family Network Centers (CFNC)
Pre-Kindergarten Registration Checklist (Page 1 of 2)

**Important Dates**

<table>
<thead>
<tr>
<th>April 12</th>
<th>Early Registration Ends</th>
<th>July-August</th>
<th>Acceptance Notifications</th>
<th>September 4</th>
<th>First Day of School</th>
</tr>
</thead>
</table>

When you come to register your child, please bring ALL of the required documents listed:

- HOME LANGUAGE SURVEY
- CFNC STUDENT REGISTRATION FORM
- STUDENT HEALTH INFORMATION FORM
- ORIGINAL BIRTH CERTIFICATE (or a Certified Birth Certificate)
- PROOF OF GUARDIANSHIP (Proof that the adult registering the child is the Parent/Legal Guardian)

Name on birth certificate should match the parent/guardian’s picture ID or court documents of legal custody.

- COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM
  - PHYSICAL EXAMINATION REPORT
    State law (Ref. Code of Virginia § 22.1-270) requires that your child receives a comprehensive physical examination in the United States before entering preschool in a public elementary school. Physical examination must be dated within one year prior to date of entry into preschool.
  - IMMUNIZATION RECORDS (Documenting month, day and year each was administered)
    - Negative Tuberculosis Risk Assessment, PPD Tuberculin Skin Test or negative Chest X-Ray, completed in the United States
      Administered within 12 months prior to child’s first day of school. Required of all children entering ACPS.
    - HEPATITIS B
      A complete series of three doses of Hepatitis B vaccine is required for all children.
    - Diphtheria, Tetanus, Pertussis (Dtap, DTP or Tdap)
      A minimum of four doses, with one dose administered on or after the fourth birthday.
    - POLIO (OPV or IPV)
      A minimum of four doses, with one dose administered on or after the fourth birthday.
    - Measles, Mumps, & Rubella (MMR)
      All children must have at least two doses of Measles, two doses of Mumps and one dose of Rubella prior to kindergarten. The first doses must be administered at 12 months of age or older.
    - Varicella (Chicken Pox)
      All children must have two doses of varicella or medical documentation of having the chicken pox disease.
    - Haemophilus Influenzae (Hib)
      This vaccine is required ONLY for children up to 60 months of age. A primary series consists of either 2 or 3 doses (depending on the manufacturer). Unvaccinated children between the ages of 15 and 60 months are only required to have one dose of vaccine.
    - Pneumococcal Vaccine (PCV)
      This vaccine is required ONLY for children less than 60 months of age. One to four doses, dependent on age of first dose of pneumococcal conjugate vaccine required.

**IMPORTANT IF IMMUNIZATIONS ARE DEFICIENT:** If new vaccines have just been administered, a licensed health care provider must advise in writing the date of the next scheduled visit for additional vaccines. Also, proper spacing of doses should be followed. When additional vaccines are received, written documentation needs to be provided to the school nurse.

**See Reverse Side**

Updated 01/16/2018 Office of Early Childhood
Proof of Residency
You MUST submit any ONE of the following documents for verification of current residency; they must be dated within the past 60 days, and only originals are accepted (no copies):
- Lease agreement
- Mortgage contract or payment receipt with address indicated
- Utility bill (water, gas, electric, cable, or landline phone)
- Personal property tax bill or receipt

Note: A driver’s license or state-issued ID does NOT serve as valid proof of residency. If you reside with someone else, you will be required to complete the ACPS Residency Affidavit, Notarized Form A and B, and submit a copy of the householder’s lease agreement and a utility bill.

Income Verification
Please supply one of the following:
- Income Tax Form 1040
- Written Statement from Employer
- W-2 (from recent year)
- Supplemental Security Income (SSI)
- 2 recent pay stubs
- Temporary Assistance for Needy Families (TANF)
- Unemployment Compensation
- Foster Care Reimbursement
- Notarized Income Verification

Enrollment Fees
___ $25 application fee
___ $150 program fee

Payment Options
_____ Cash
_____ Check
_____ Credit Card
Home Language Survey

Parent/Guardian: Federal regulations require school systems to survey all enrolling students regarding the students' home language and any other languages the students may speak. Based on the information provided below, the student may be assessed for English proficiency as required by federal regulations. Based on the results of the assessment, the student may be eligible for supplemental instruction through the English Learner (EL) program. Parents/guardians will be informed about the assessment results and if the student is eligible for supplemental services, the parents will have the opportunity to accept or refuse the supplemental EL services.

Padre, madre o tutor legal: Las leyes federales requieren que los sistemas escolares encuesten a todos los alumnos sobre el idioma que se habla en el hogar y sobre cualquier otro idioma que puedan hablar los alumnos. Con base en la información proporcionada a continuación, el alumno pudiera ser evaluado para determinar su competencia en el idioma inglés tal como lo exigen las normas federales. Con base en los resultados de la evaluación, el alumno pudiera ser elegible para recibir instrucción suplementaria mediante el programa de Aprendizaje del Idioma Inglés (EL). Se informará a los padres o tutores legales sobre los resultados de la evaluación y si el alumno es elegible para recibir servicios suplementarios, los padres tendrán la oportunidad de aceptar o rechazar los servicios suplementarios de EL.

Student Name: ___________________________ Date of Birth: ___________________________
Nombre del alumno Fecha de nacimiento
495-678-9012 345-678-9012
Nombre del padre, madre o tutor legal
Fecha de nacimiento
495-678-9012 345-678-9012

1. What is the primary language used in the home, regardless of the language spoken by the student?
¿Cuál es el idioma principalmente utilizado en el hogar, independientemente del idioma que el alumno habla?
ماهي اللغة الأساسية المستخدمة في البيت، بغض النظر عن اللغة التي يتحدث بها الطالب?

2. What is the language most often spoken by the student?
¿Cuál es el idioma que el alumno habla con más frecuencia?
ماهي اللغة التي يتحدث بها الطالب غالباً?

3. What is the language that the student first acquired?
¿Cuál es el idioma que el alumno aprendió primero?
ماهي اللغة التي تعلمه الطفل لأول مرة?

In which language do you prefer to receive communication from the school? □ English □ Español □ عربية □ Other
¿En qué idioma prefiere recibir comunicación de la escuela?
ماهي اللغة التي تفضل التواصل بها المدرسة؟

□ Other: ___________________________
Otro

Parent/Guardian Signature: ___________________________ Date: ___________________________
Firma del padre, madre o tutor legal
Fecha
# STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Student's Last Name: __________________________</th>
<th>First Name: __________________________</th>
<th>Middle Name: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student and Primary Parent/Guardian Address: Street __________________________</td>
<td>Apt # __________________________</td>
<td></td>
</tr>
<tr>
<td>City __________________________ State __________ Zip __________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Male ☐ Female</td>
<td>Date of Birth: Mo: _____ Day: _____ Year: _____</td>
<td>Country of Birth: __________________________</td>
</tr>
</tbody>
</table>

Is this student Hispanic or Latino? (choose only one)

☐ No, not Hispanic or Latino  ☐ Yes, Hispanic or Latino (person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

What is the student's race? (choose one or more)

☐ American Indian/Alaskan  ☐ Black or African American  ☐ Asian  ☐ Native Hawaiian or Other Pacific Islander  ☐ White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

If a language other than English is spoken in the student’s home, what is that language?

☐ Spanish  ☐ Amharic  ☐ Arabic  ☐ Other (please specify) __________________________

# PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian:
*This is the parent/legal guardian with whom the student lives most of the week, and the main contact regarding the student.*

Do you live/reside in the City of Alexandria? ☐ Yes ☐ No  If No, has an exception to policy been approved? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Last Name: __________________________</th>
<th>First Name: __________________________</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Father ☐ Stepfather ☐ Legal Guardian</td>
<td>☐ Mother ☐ Stepmother ☐ Foster Parent</td>
<td></td>
</tr>
</tbody>
</table>

Other (please indicate relationship): __________________________

Home Phone: (____) ______-_______  Is your home phone a cell phone? ☐ Yes ☐ No

Cell Phone: (____) ______-_______

Email Address: __________________________

Parent/Guardian's preferred language of communication?

☐ English  ☐ Spanish  ☐ Amharic  ☐ Arabic  ☐ Other (please specify) __________________________

Country of Birth: __________________________

Highest Education Level: ☐ Elementary School ☐ Middle School ☐ High School ☐ College ☐ Graduate School

Parent/Guardian #2:

<table>
<thead>
<tr>
<th>Last Name: __________________________</th>
<th>First Name: __________________________</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Father ☐ Stepfather ☐ Legal Guardian</td>
<td>☐ Mother ☐ Stepmother ☐ Foster Parent</td>
<td></td>
</tr>
</tbody>
</table>

Other (please indicate relationship): __________________________

Address: ☐ Address is the same as student and primary parent/guardian’s address above

<table>
<thead>
<tr>
<th>Street __________________________</th>
<th>Apt # __________________________</th>
<th>City __________________________ State __________ Zip __________</th>
</tr>
</thead>
</table>

Home Phone: (____) ______-_______  Is your home phone a cell phone? ☐ Yes ☐ No

Cell Phone: (____) ______-_______

Email Address: __________________________

Country of Birth: __________________________

Highest Education Level: ☐ Elementary School ☐ Middle School ☐ High School ☐ College ☐ Graduate School

Revised 1/2017 Communications Office dnbnm
STUDENT REGISTRATION FORM • Page 2 of 2
The Child & Family Network Centers

STUDENT BACKGROUND

Does your child have a current IEP for Special Education services or 504 Plan? ☐ Yes ☐ No
If Yes, has documentation been provided to the school? ☐ Yes ☐ No

STUDENT’S SIBLINGS and other household members

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Relationship</th>
</tr>
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</tbody>
</table>

Authorized Release List

Please list the persons who may pick up your child from CFNC. Include carpool drivers, neighbors, grandparents, etc. The person picking up your child may be asked to provide some identification.

Contact #1
Name: __________________________
Home Phone: (____) ______-_______ Cell Phone: (____) ______-_______
Relationship to student: __________________________

Contact #2
Name: __________________________
Home Phone: (____) ______-_______ Cell Phone: (____) ______-_______
Relationship to student: __________________________

Contact #3
Name: __________________________
Home Phone: (____) ______-_______ Cell Phone: (____) ______-_______
Relationship to student: __________________________

Contact #4
Name: __________________________
Home Phone: (____) ______-_______ Cell Phone: (____) ______-_______
Relationship to student: __________________________

By signing this form I am verifying that the information contained herein is correct.
Parent/Guardian Signature: __________________________ Date: __________________________

FOR OFFICE USE ONLY

How will you transport your child to school? ☐ Car ☐ Walking ☐ Public Transportation (Bus)
Student's Last Name: ________________________________  First Name: ________________________________

Date of Birth: ________________________________  Grade: ________________________________  School Year: ________________________________

Please list at least two people we may call to make emergency decisions and/or pick up your child from school if the parent(s)/guardian(s) cannot be reached in the event of an emergency:

**Emergency Contact #1 (Other than Parent/Guardian):**

Name: ______________________________________
Address: Street ________________________________  Apt # __________
City __________________ State ________ Zip __________
Home Phone: (_____) _____ - ________  Cell Phone: (_____) _____ - ________
Work Phone: (_____) _____ - ________
Relationship to student: ______________________________________

**Emergency Contact #2 (Other than Parent/Guardian):**

Name: ______________________________________
Address: Street ________________________________  Apt # __________
City __________________ State ________ Zip __________
Home Phone: (_____) _____ - ________  Cell Phone: (_____) _____ - ________
Work Phone: (_____) _____ - ________
Relationship to student: ______________________________________

**STUDENT HEALTH CONDITIONS**
Check all boxes that apply to the student.

### ALLERGIES

- [ ] Yes  
- [ ] No

**Allergy Type:**

- [ ] Food  List food(s):
- [ ] Medication  List medication(s):
- [ ] Bee stings or insect bites
- [ ] Other: ________________________________

Date of last severe reaction: ________________________________

### FOOD RESTRICTIONS

- [ ] Yes  
- [ ] No

- [ ] Due to Gastrointestinal (Digestive) distress  List food(s):
- [ ] Due to religious or other preferences  List food(s):

### ASTHMA

- [ ] Yes  
- [ ] No

Currently prescribed medications and treatments for asthma:

- [ ] Daily control (prevention) medication
- [ ] As needed (rescue) medication

Date of last hospital or emergency room visit due to asthma: ________________________________
### OTHER HEALTH CONDITIONS

- **Yes**
- **No**

- [ ] Other physical or mental health conditions: ____________________________

**Does the student's condition require IN SCHOOL USE of the following?**

- **Medications:**
  - [ ] No
  - [ ] Yes
  - List medication(s): ____________________________

- **Special procedures:**
  - [ ] No
  - [ ] Yes
  - List procedure(s): ____________________________

- **Special equipment:**
  - [ ] No
  - [ ] Yes
  - List equipment: ____________________________

### VISION CONDITIONS

- **Yes**
- **No**

- [ ] Glasses
- [ ] Contacts
- [ ] Non correctable
- [ ] Other: ____________________________

### HEARING CONDITIONS

- **Yes**
- **No**

- [ ] Hearing aid(s)
- [ ] Non correctable
- [ ] Other: ____________________________

### STUDENT HEALTH CARE AND HEALTH COVERAGE

**Does the student have health insurance?**

- [ ] No
- [ ] Yes

- Name of health insurance company: ____________________________

- Name of student’s primary care doctor: ____________________________
  - Phone: ____________________________

**Does the student have dental insurance?**

- [ ] No
- [ ] Yes

- Name of dental insurance company: ____________________________

- Name of student’s dentist: ____________________________
  - Phone: ____________________________

### PARENT/GUARDIAN AUTHORIZATION

In the case of an emergency, school staff will call 911. Every attempt will be made to contact a parent, legal guardian or emergency contact.

The parent/guardian is responsible for providing the school with any medication, special food or equipment that the student requires during the school day. Check with the school nurse or registrar to obtain correct medication and procedural forms. If an individual school health care plan is indicated, the parent/guardian is responsible for providing the school nurse with necessary medical information, appropriate authorization forms and written consent to exchange information with the child's physician.

I, ___________________________________________ (do __) (do not __) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child’s health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child’s school. When information is released from your child’s record, documentation of the disclosure is maintained in your child’s health or scholastic record.

Parent/Guardian Signature: ____________________________ Date: ____________________________
PARENT RESPONSIBILITIES

PARENT AGREEMENT:
I have received a copy of the Parent Agreement Forms, and I understand and agree to all policies and requirements therein.

Parent/Guardian Signature _______________________________ Date ______

SCREENINGS:
I give permission for my child _____________ to receive Dental, Vision, and Hearing screenings.

YES_______ No_______

Parent/Guardian Signature _______________________________ Date ______

OBSERVATION:
I give permission for a credentialed provider, from the Community Services Board, Preschool Prevention Team, to observe my child as appropriate in his/her classroom, and for that provider to consult with the teaching/family support staff as necessary.

Yes_______ No_______

Parent/Guardian Signature _______________________________ Date ______

ELEMENTARY SCHOOL RECORDS:
In order to provide a smooth transition to kindergarten, The Child & Family Network Centers will convey your child’s preschool academic records to the Alexandria City Public Schools.
By my signature below, I grant permission for my child’s preschool records to be released to his/her elementary school.

Parent/Guardian Signature _______________________________ Date ______

ELEMENTARY SCHOOL FOLLOW-UP
The Child & Family Network Centers is constantly evaluating its academic program to ensure that we are providing the highest quality kindergarten preparation for your child. To evaluate our program we need to follow the academic performance, including grades and test scores of your child through elementary and high school. This evaluation is kept strictly confidential and is used only for the purpose of evaluating The Child & Family Network Centers.
I grant permission for my child’s elementary school to release his/her academic records to The Child & Family Network Centers.

Parent/Guardian Signature _______________________________ Date ______

Child’s Name _______________________________ Date ______

WAIVER OF LIABILITY
In consideration for the services provided to my child(ren), I, for myself and my child(ren), my and their personal representatives, spouse, assigns, heirs, and next of kin, hereby indemnify, release, hold harmless, and forever discharge The Child & Family Network Centers, as well as its officers, directors, agents, employees, successors, affiliates, and assigns (the “Releasees”) from all liability, claims, demands, losses, costs or damages, whether known or unknown, that I ever had or may have, arising from or in any way related to the services provided by the Releasees, including, but not limited to, allergy exposure or any bodily harm or injury to my child(ren), except only for loss, harms or injury occasioned by gross negligence, or intentional, willful, or wanton misconduct.

Parent/Guardian Signature _______________________________ Date ______

Revised March 2018

3700 Wheeler Avenue, Alexandria, Virginia 22304
Phone (703) 836-0214, Fax (703) 836-3180
CFNC RELEASE FOR PHOTOGRAPHS AND VIDEOTAPEING

From time to time, photographs and videos (collectively, the “images”) are taken at The Child & Family Network Centers (“CFNC”) for use on the CFNC website and social media pages like Facebook and Twitter, in publications (including the CFNC electronic newsletter), brochures, marketing and publicity materials to promote CFNC, as well as for use in child portfolios, classroom books, and staff training (collectively, the “Materials”). These images may include your child.

We will not use your child’s full name in marketing and or publicity materials for CFNC without your expressed consent, nor will your child’s full name be used in the CFNC electronic newsletter or the CFNC website or social media pages without your permission.

I, ______________________________. (Print name of Parent/ Guardian)

(circle one)  Give permission / Do not give permission

For CFNC to photograph and videotape my child while he/ she attends CFNC. I agree that such images and recordings may be included in the Materials for the purposes of marketing and publicity about CFNC and for educational training purposes and may be broadcast in any and all media anywhere in the world in perpetuity. CFNC may edit such images and recordings at their sole discretion, without my approval.

I hereby assign all rights, title, and interest, in perpetuity and without right to compensation, my child(ren) or I may have in any and all images (as defined above) now known or hereafter developed in which any or all of my child(ren)’s appearance, name, voice, and/or likeness have been captured in connection with the Materials.

I hereby attest that I have read, and agree to the above statement on this _____ (day) of ______________________ ( month), __________(year).

SIGNATURE: __________________________________________________________

Child’s Name: ___________________________ DOB: _______________________

Phone: ______________________________________________________________

Email: ______________________________________________________________

Revised March 2018
THE CHILD & FAMILY NETWORK CENTERS
PARENT/GUARDIAN AGREEMENT

PARTICIPATION REQUIREMENTS:  

1. I agree to participate in Parent Orientation/Back-to-School Night.  
   __       __

2. I agree to participate in two Parent/Teacher Conferences during the school year.  
   __       __

3. I agree to participate in at least one (1) Kindergarten Transition workshop.  
   __       __

4. I agree to allow my child to receive services from the Family Support Worker.  
   __       __

5. I agree to allow the Family Support Worker to make two home visits during the current school year.  
   __       __

6. I agree to participate in three of the following: parent advisory committee meetings, parent workshops, and special events.  
   __       __

HEALTH AND SAFETY REQUIREMENTS  

1. I agree that I will walk my child into the classroom each school day, sign in the morning, and sign out at the end of the day.  
   __       __

2. I agree that if my child has a fever of 101 degrees, vomiting, or diarrhea, I will not bring him/her to school and that my child will not be allowed to return to school until 24 hours after the fever, vomiting, or diarrhea is gone.  
   __       __

3. I understand that if my child gets sick during the school day that I will be called to come and pick him/her up within 30-45 minutes. If I cannot be reached, the school will call the people on the Emergency or Pick-Up List until someone can be reached to pick up my child. I will be notified as to who has picked up my child.  
   __       __

4. I AGREE TO INFORM THE SCHOOL IMMEDIATELY OR BEFORE THE NEXT SCHOOL DAY IF MY CHILD HAS OR HAS BEEN EXPOSED TO ANYONE WITH AN INFECTIONIOUS DISEASE.  
   __       __
5. I understand that no medication will be given without proper written authorization and instructions from a physician. (Please see parent handbook) all medications must be in the original containers with pharmacy labeling including the child's name.  

6. I agree to keep the school informed of any changes of my phone numbers including home, work, and cell and of any additional phone numbers both for emergency contacts and those persons authorized to pick up my child from school. I also agree that the school may ask for a picture identification of any person sent to pick up my child other than a parent.  

7. ATTENDANCE: I agree that daily attendance is very important for my child and makes a difference in learning. It is important for my child to attend school every day unless he/she is sick. I agree to bring my child every day and understand that if a child is absent often without a justified reason that the school may terminate her/his placement and fill that space with another child.  

8. Enrollment: I understand that CFNC is a private, nonprofit child-care center and the CFNC reserves the right to terminate a child’s enrollment in any CFNC program at the discretion of the CFNC’s Executive Director or Board of Directors.  

Revised March, 2017
**THE CHILD & FAMILY NETWORK CENTERS**

**Enrollment:** (We do not offer half day schedules in any classroom)

Please indicate which location is ideal for you and if you need after-care

**Wheeler**
3700 Wheeler Avenue
Alexandria, VA 22304

- 8am to 3pm
- 3pm to 6pm (After-care)

**Alive**
2723 King Street
Alexandria, VA 22302

Mon-Fri 8am-3pm
No After-care

**3801**
3801 Mount Vernon Avenue
Alexandria, VA 22305

- 8am to 3pm
- 3pm to 6pm (After-care)

**Chirilagua**
3918 A Bruce Street, #101
Alexandria, VA 22305

- 8am to 3pm
No After-care

**Cora Kelly**
25 W. Reed Avenue
Alexandria, VA 22305

- 8am to 3pm

*All children will receive breakfast, lunch, and afternoon snack at their centers*

*Food program sponsored by: Virginia Department of Health (USDA)*

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3700 Wheeler Avenue, Alexandria, Virginia 22304
Phone (703) 836-0214, Fax (703) 836-3180