2024 ENROLLMENT AGREEMENT

[ ] REP STUDENT [ ] VKC STUDENT

VICTORY KIDZ CARE
VICTORY CHURCH

2870 Middle Road Winchester, VA 22601
Phone: 540-667-9400 ext.125 / Fax: 540-667-9604
vkc@victorywinchester.com

2024 ENROLLMENT AGREEMENT

Full Name of **Child**_____

Name Child is **Called**_____

Birth Date_____/_____/_____ Male_____ Female_____ Full Name of **Mother**_____

Mailing Address_____

City _____ ST_____ ZIP_____

Home # (___)_____ Business # (___)_____ Cell # _____

Email _____

Place of Business_____

Full Name of **Father**_____

Mailing Address_____

City _____ ST_____ ZIP_____

Home Phone (___)_____ Business Phone (___)_____ Cell # _____

Email_____

Place of Business_____

EMERGENCY NAMES AND PHONE NUMBERS:

Child's Physician_____ Phone (_____)_____

Names and Phone Numbers of persons, other than parents, to whom we may release your child:

Please list two people and their relationship to the child in case parents cannot be reached.

Name_____ Phone (_____)_____

Relationship _____ Cell (_____)_____

Name_____ Phone (_____)_____

Relationship _____ Cell (_____)_____

FAMILY INFORMATION FORM

Our household includes (names and ages):

Mom:_____

Dad:_____

Sisters:_____

Brothers:_____

Others:_____

Any additional information:_____

Does your child have a pet?

Kind:_____ Name:_____

Kind:_____ Name:_____

Does your child have other opportunities to interact with other children, if yes, where? _____

What communicable diseases has your child had? Indicate date or age:

Chicken Pox _____ Scarlet Fever_____ Impetigo_____

Conjunctivitis_____

Does your child have any allergies? _____

If so, please list them:_____

Does your child have frequent:

Coughs_____ Colds_____ Fever_____

Ear Infections_____ Upset Stomach_____ Convulsions_____

Seizures_____

Is there any physical or emotional condition that we need to know about to properly care for your child? (Explain)_____

_____

Please give any special instructions or additional information you may think would be important for us to have: _____

_____

VICTORY KIDZ CARE

Child's Name _____

Address _____

City _____ ST ____ ZIP _____

Proof of age and identity (check one): Birth Certificate _____ Other _____ If other, explain, list document, and enclose with this form. The original will be returned to you.

Previous childcare programs and schools this child has attended:

Name of Program City State Dates

_____

_____

_____

PLEASE SELECT DAYS YOUR CHILD WILL BE ATTENDING and DROP OFF/PICK UP TIMES:

Monday_____ Drop Off Time _____Pick up Time_____

Tuesday_____ Drop Off Time _____Pick up Time_____

Wednesday_____ Drop Off Time _____Pick up Time_____

Thursday_____ Drop Off Time _____Pick up Time_____

Friday _____ Drop Off Time _____Pick up Time_____

Full Day_____ Half Day (4.5 hrs. max) _____ After School_____

PERMISSION FOR EMERGENCY TREATMENT

Name of Child_____

In the event of an emergency or accident which requires immediate medical treatment and/or at a time when a parent cannot be located, I give permission for the Director, or any staff member at Victory Church or Victory Kidz Care to authorize such treatment. I will not hold Victory Church, or its employees, Pastors, Board, or members, or any medical personnel liable in any way. This is done with the understanding that every reasonable attempt will have been made to contact the parents or legal guardians.

Date_____ Signed _____
(Parent or Legal Guardian)

Health Insurance

Company_____

Policy #_____

Group #_____

Subscriber #_____

Important Medical Information (food or medication allergies, asthma, heart problems, diabetes, etc.)

_____

_____

_____

_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official. See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.

Student's Name: _____ Date of Birth: | | | |
Last First Middle Mo. Day Yr.

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
		2 3 4 5			
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1				
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV)	1	2	3		
❑Merck adult formulation used					
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus	1	2	3		
Vaccine Other	1	2	3	4	5

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Official in the appropriate box.

PLEASE NOTE THAT THE REGISTRATION FEE AND ___FORMS, INCLUDING IMMUNIZATION RECORD (a copy is acceptable) *MUST* ACCOMPANY THIS FORM! PLEASE NOTE THAT WE WILL NEED TO SEE AN *ORIGINAL BIRTH CERTIFICATE*

(FOR OFFICE USE ONLY)

FORM: DATE:

____ Enrollment Agreement Received _____/_____/_____

____ Registration Fee Received (one time, $50 per family) _____/_____/_____

____ Emergency Treatment Form Received _____/_____/_____

____ Family Information Form Received _____/_____/_____

____ Up-to-Date Immunization Record Received _____/_____/_____

_____Birth Certificate State & Number _____/_____/_____

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Name of Child _____

I have received a copy of the handbook of policies including the public disclosure statement and staff position requirements. I have read and understand these policies.

Date _____ Signed, _____
(Parent or Legal Guardian)