



**Other Fees:** *(Please check all that apply and indicate cost if additional fees apply)*

- Registration fee \$ \_\_\_\_\_  Late Fee \$ \_\_\_\_\_  Summer Activity Fee \$ \_\_\_\_\_  Holiday Fee \$ \_\_\_\_\_  Insurance \$ \_\_\_\_\_  
 Sick Child Fee \$ \_\_\_\_\_  Supply Fee \$ \_\_\_\_\_  Transportation Fee \$ \_\_\_\_\_  Extended Day Fee \$ \_\_\_\_\_  Meal Fee \$ \_\_\_\_\_

**Meals:** *(Check meals served)*

- Breakfast  AM Snack  Lunch  PM Snack  Dinner  Evening Snack  
 Parent provides meals  USDA Food Program  Special meal request

**Services / Environment:** *(Please check all that apply)*

- Full time (30 or more hrs per wk)  Evening care  Before School  Non-smoking  Air conditioned  
 Part Time (29 or fewer hours per week)  Overnight Care  After school  No indoor pets  Fenced yard  
 Drop in (not enrolled for regular care)  Holiday Care  Sick child care  No outdoor pets  No weapons  
 Temporary / Emergency / Backup  Open all year  No kerosene heater  No Pool  
 Respite Care  Open summer only  No wood-burning stove  Field trips  
 Rotating Shift Care  Open school year only  Wheelchair accessible

**Financial Assistance:** *(Please check all that apply)*

- Accept:  Public Funds  State Subsidy (DSS funds)  Private Subsidy/Scholarships  
 Provide:  Scholarships  Sliding Fee Scale  Other \_\_\_\_\_

**Policies:**  Written Contract  Handbook  Multi-child Discount  Liability Insurance

- Provider Sick Allowance  Provider Vacation Allowance  Child Absence Allowance

**Safety:**  CPR Certified  First Aid Certified  Medication Administration Certified  Health-Related Degree  On-Site Nurse

**Special Needs:** *(Please check all that apply)*

- Adaptive Special Equipment  Asthma/Respiratory  Allergies  ADD/ADHD  Autism / Aspergers  
 CP/Neuralgic/Seizure Disorders  Developmental Delay  Cognitive  Diabetes  Down Syndrome  
 Post Traumatic Stress Disorder  Medical  ODD  Physical  Social / Emotional  
 Learning disabled resources  Space for therapy  PT/OT  Experience/Training or desire to provide care

**Experience:** *(Center Director or Family Child Care Provider)*

- Family Child Care experience  Child Care Center experience  
 Under 1 year  1 to 3 years  4 to 9 years  10 to 20 years  Over 21 years

**Training / Education:** *(Refers to the Center Director or Family Child Care Provider - specify area of study)*

- High School Education  0-12 hrs training  13+ hrs training  Credit-based training  Some College \_\_\_\_\_  
 CDA  Associate degree in \_\_\_\_\_  Bachelor degree in \_\_\_\_\_  Master degree in \_\_\_\_\_

**Accreditation:**  NAEYC  NAFCC  NECPA  NAC  NAA  COA  ACA

PLEASE FAX OR ATTACH A COPY OF YOUR ACCREDITATION PAPERWORK TO THIS FORM.

**Affiliation:**  NAFCC  NAEYC  VAFCCA  VAECE  Local Family Child Care Assoc  Local AEYC

**Child Advocacy Issues**  Will visit legislators  Will contact legislators  Will write letters  Will make phone tree calls

**Enrollment Requirements:**  Orientation  Medical Authorization  Physical-Health Record  Parent Information  Proof of Birth

**Curriculum:**  ABEKA  Creative Curriculum  High Reach  High Scope  Houghton Mifflin Pre-K  
 Montessori  Mother Goose  Pinnacle  Reggio  Other \_\_\_\_\_

**DO NOT include my information for:**  Web Referrals  Referrals to Parents  Rates  Training Information mailings

**Sworn Disclosure:**

I certify that the information on this form is true and correct, and that I am legally operating within the laws and child care regulations of the Commonwealth of Virginia. *(Section §63.2-1727 of the Code of Virginia prohibits any person from operating a family day home if he, or if he knows that any person who resides, is employed by, or volunteers in the home, is a convicted sex offender or has a founded complaint of child abuse or neglect within or outside the Commonwealth.)* I agree to enroll children without regard to race, color, religion, sex, age, veteran status, national origin, disability or political affiliation. I agree to notify (CCRR) within 30 days of any changes in the child care facility's phone number, address, regulation or certification status.

Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

Office use only:

Date entered into database: \_\_\_\_\_

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