

# Sparks Adaptive Development Academy

## REGISTRATION FORM



• Where Every Child Deserves a Chance •

515 Pratt Street  
Fredericksburg, VA 22405

Tele: 540-618-4115

Email: [Sparksadaptivedevelopment@gmail.com](mailto:Sparksadaptivedevelopment@gmail.com)

*Where Every Child Deserve a Chance*

***\*\*Office Use Only \*\* Registration Form***

*Application Date:* \_\_\_\_\_

*Enrollment Date:* \_\_\_\_\_

*Withdrawal Date:* \_\_\_\_\_

*Classroom Assignment:* \_\_\_\_\_

### STUDENT INFORMATION

CHILD'S FULL NAME: \_\_\_\_\_

NICKNAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE AS OF THIS SEPT. 30: \_\_\_\_\_

GENDER: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

CHILD LIVES WITH:

\_\_\_\_\_

WHO HAS CUSTODY OF CHILD, IF OTHER THAN PARENT:

\_\_\_\_\_

### MOTHER/GUARDIAN

NAME: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

MOTHER'S EMAIL ADDRESS: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ SAME AS CHILD OR

\_\_\_\_\_

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### FATHER/GUARDIAN

NAME: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

FATHER'S EMAIL ADDRESS: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ SAME AS CHILD OR

\_\_\_\_\_

### EMERGENCY CONTACTS AND AUTHORIZED PICK-UP PERSONS

Must have TWO local contacts other than child's parents

#### NAME & ADDRESS:

1. \_\_\_\_\_

\_\_\_\_\_  
CONTACT NUMBER: \_\_\_\_\_

#### NAME & ADDRESS:

2. \_\_\_\_\_

\_\_\_\_\_  
CONTACT NUMBER: \_\_\_\_\_

PLEASE LIST ANY PERSON(S) NOT AUTHORIZED TO PICK UP YOUR CHILD OR ENTER  
N/A:

\_\_\_\_\_

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### MEDICAL INFORMATION

PHYSICIAN: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

ALLERGIES/INTOLERANCES: \_\_\_\_\_ NO \_\_\_\_\_ YES

LIST: \_\_\_\_\_

EMERGENCY MEDICATION REQUIRED (EPI-PEN, INHALER, ETC):

\_\_\_\_\_

SPECIAL DIETARY REQUIREMENTS: \_\_\_\_\_ NO \_\_\_\_\_ YES

LIST: \_\_\_\_\_

ANY CHRONIC PHYSICAL PROBLEMS OR DEVELOPMENTAL CONCERNS:

\_\_\_\_\_ NO \_\_\_\_\_ YES DESCRIBE: \_\_\_\_\_

\_\_\_\_\_

LIST CHILD'S PREVIOUS DAY CARE(S) ATTENDED:

\_\_\_\_\_

\_\_\_\_\_ OR \_\_\_\_\_ N/A

ANY OTHER SCHOOL CHILD ATTENDS:

\_\_\_\_\_ GRADE: \_\_\_\_\_ OR \_\_\_\_\_ N/A

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### AGREEMENTS

1. Sparks Adaptive Development Academy 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 Sparks Adaptive Development Academy to obtain medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. \*\*
3. The parent(s)/guardian(s) agree to inform the center within 24 hours, or the next business day, after the 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.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SADA DIRECTOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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

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Birth Certificate Number: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Date Issued: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Person Viewing Document: \_\_\_\_\_ Date Document Viewed: \_\_\_\_\_  
Other Form of Proof: \_\_\_\_\_

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

Re-verification: Annual review of information accuracy: : \_\_\_\_\_ / \_\_\_\_\_  
Initials Date  
\_\_\_\_\_ / \_\_\_\_\_  
Initials Date

### Disclosure Statement

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 or adoption agency), record from a public school in New York, certification by a principal or their 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.

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Section 63.2-1809 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 undecipherable by any means.

Additionally, 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 non-custodial parent of a student enrolled in a public school or day care center must be included, upon the request of such non-custodial parent, as an emergency contact for events occurring during school or day care activities.