



Dear Parents,

Thank you for your interest in Sparkles! @ White Oaks. Enclosed you will find information about our program, and we would be happy to arrange a meeting with you to answer any additional questions that you may have.

Registration form (with a non-refundable Registration Fee) are being accepted now on a first-come, first serve basis. Upon acceptance, an Enrollment Agreement and additional paperwork will be given to you, which must be completed and returned in order to reserve the child's place in the program.

Our hours of operation for our Before School Program Monday to Friday are from 7:00 a.m. to first school bell and for our After School Program Monday through Friday are dismiss bell to 6:15pm. We offer 3 programs: Before and After School, After School only and Before School only.

Our logo is a star with human features symbolizing the ability for each and every one of us to shine given the right opportunities. We have affectionately named it "Lucky", because we indeed need to thank our "Lucky Star" when we are able to trust others with the care of our children. We will earn that trust!

Please feel free to call us or visit our website at www.sparklesontheweb.com and email us if you have any additional questions.

Sincerely,

Diana Rodriguez

Program Director

whiteoaks@sparklesontheweb.com

Phone (703) 501-1709



At White Oaks Extended Care

Price List School Year 2017-18

Rooms	Monthly Prices
	Full Time
Before School	\$170.00
After School	\$350.00
Before & After School	\$480.00

Payments required at the time of registration:

- ❖ Registration Fees: \$30.00 per child (Non-refundable)
(Re-registration fee of \$30.00 per child will be collected annually)

Additional tuition information:

- ❖ Tuition rates are monthly to be paid by the 1st of each month before services are rendered.
- ❖ Siblings receive a 10% discount applied to the oldest child's tuition.
- ❖ Discounts cannot be used in combination with any other promotion/discount.



**At White Oaks Extended Care
CHILD REGISTRATION**

Parent Signature: _____ **Date:** _____

Child name:	Nickname:	Date of Birth:	Sex:
Address:		Home Phone:	
Chronic Physical Problems/Pertinent Development Information/Special Accommodations Needed:			
Previous Child Day Care Programs and Schools Attended			
Grade	White Oaks Teacher's Name		Room Number
Program <input type="checkbox"/> Before & After School <input type="checkbox"/> Before School Only <input type="checkbox"/> After School Only			

PARENT (S)/GUARDIAN (S)

Father name:	Place Employed:	Business Phone:
Home Address:		Home Phone:
Ok to send information via email: Yes <input type="checkbox"/> No <input type="checkbox"/>	Primary e-mail Address:	Secondary e-mail Address:
City/State:	Zip Code:	Cell Phone:
Mother name:	Place Employed:	Business Phone:
Home Address:		Home Phone:
Ok to send information via email: Yes <input type="checkbox"/> No <input type="checkbox"/>	Primary e-mail Address:	Secondary e-mail Address:
City/State:	Zip Code:	Cell Phone:
Person (s) or Agency Having Legal Custody of Child:		
Home Address:		Home Phone:
Business Address:		Business Phone:

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to take in an Emergency:		
Child's Physician:	Phone:	
Two People To Contact if Parent (s) Cannot Be Reached	Address:	Phone:
1.		
2.		
Person (s) Authorized To Pick Up Child		
Person (s) <u>NOT</u> Authorized To Pick Up Child*		



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

AGREEMENTS

1. The child day care 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 the child day care to obtain immediate 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 next business day after his 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.

SIGNATURES

Parent (s) or Guardian (s)	Date
Administrator of Center	Date

Date Child Entered Care: _____ **Date Left Care** _____

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

**OFFICIAL USE ONLY
IDENTITY VERIFICATION**

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

Place of Birth:	Birth Date:	Birth Certificate Number:	Date Issued:
Other Form of Proof:	Date Documentation Viewed:	Person Viewing Documentation:	

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

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), copy of the placement agreement or other proof of the child’s identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U.S. that a certificated copy of the child’s birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of child to an independent foster parent. Viewing the child’s proof of identity is not necessary when the child attends 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.

Section 63.2-1809 of the code of Virginia states that the proof of identity states that the proof of identity, if produced 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) therwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means.



At White Oaks Extended Care

**ENROLLMENT AGREEMENT BETWEEN
Parents or Legal Guardians (“Parents”) and Sparkles! at White Oaks**

I/we understand and agree that this “Enrollment Agreement” represents only a summary of key Sparkles! policies. By signing this Enrollment Agreement I/we affirm that I/we have read and understand the Enrollment Agreement as well as the Sparkles! Parent Handbook, and agree to abide by all policies and procedures contained therein.

I/WE AGREE TO ALL OF THE FOLLOWING IN THIS ENROLLMENT AGREEMENT:

I/we hereby enroll my/our child, _____, in Sparkles! at White Oaks . The program the child will be enrolled in is _____. Enrollment begins on _____ and may be terminated at any time with a minimum **two (2)-week written notice of withdraw or by Sparkles! pursuant to the terms of this Enrollment Agreement and/or the terms of the Parent Handbook.**

TUITION, REGISTRATION FEE & DEPOSIT

1. I/we agree to pay the Monthly Tuition of \$_____. Monthly Tuition payments are non refundable and will not be pro-rated.
2. I/we agree to pay Monthly Tuition by the 1st of each month before services are rendered. I/we understand and agree that payments received after the 1st of the month are considered late tuition payments and must include a \$25 late-penalty charge.
3. I/we agree to pay a Registration Fee of _____ which is due at time of registration. This Registration Fee is non-refundable, and is collected thereafter annually during the month of September.
4. I/we agree that a returned check from the bank is assessed a processing fee of \$25.00. I/we understand that credit cards or money orders will be the only form of payment after one (1) returned check by the bank.

ADDITIONAL TERMS

1. I/we understand and agree that there is no reduction of fees or refunds for days missed due to illness, snow, vacation or holidays. Full monthly Tuition is payable each week that the child is enrolled. In order to hold your child(ren)’s place at the Center, I/we agree to pay Weekly Tuition regardless of absence or reason, including illness or vacation.
2. I/we further understand that Monthly Tuition and fees are subject to change upon thirty days notice. I/we understand that Monthly Tuition or other fees are reviewed on a yearly basis and that I/we will be given thirty (30) days notice of any changes to the Monthly Tuition or fees. See Parent Handbook for further details regarding fees.
3. I/we understand and agree that continued enrollment is dependent on prompt tuition payment. Receipts for payments received are available upon request.
4. I give permission for Sparkles! to charge my/our credit card on file any balance due after termination of enrollment. _____ (Initial).
5. I/we understand and agree that Sparkles! charges interest in the amount of 1.5% per month for past due payments more than one month over due. I/we agree to reimburse Sparkles! for any and all fees and costs associated with collection of past due accounts, including court costs and attorney’s fees if the account goes to collection.
6. I/we understand and agree that daycare is closed at 6:15pm, and that Sparkles! charges additional fees for Late Pick Up as is stated in the Parent Handbook. I/we agree to pay Late Pick Up fees at the time of pick-up by check or credit card.
7. I/we understand and agree that Sparkles! reserves the right to terminate enrollment if late arrival for pick up is habitual.



At White Oaks Extended Care

WITHDRAWAL

1. I/we understand that a two-week advance notice is required when a child is voluntarily withdrawn from the Center. A minimum of two weeks tuition will be charged from the day that the written notice is given.
2. I/we understand that a child may be dismissed from the Center if the child's physical or mental health constitutes a hazard to other children or staff or other grounds for dismissal exist as outlined in the Parent Handbook.
3. I/we understand that a child may be dismissed from the Center if the child cannot adjust to the Center's program and is still not able to adjust after a discussion with the parent regarding the ability of the child to participate.
4. I/we understand that a child may be dismissed if a parent's language or actions are abusive to the children and/or to staff.

HEALTH AND SAFETY

1. I/we agree to ensure that a Sparkles!'s teacher is present before I/we release my/our child(ren).
2. I/we agree that no prescribed medication will be administered without written permission from parents on Sparkles' Medication Form and written instructions from a physician. I/we understand that all prescribed medications will be contained in the dated original container. I/we understand that no over the counter medications will be administered.
3. I/we understand and agree to have my/our child(ren) picked up as soon as possible within one hour of notification that my/our child(ren) have become ill or hurt or when requested by the Center.
4. I/we agree to inform the Sparkles! Center within 24 hours or the next business day after my/our child(ren), or any member of the immediate household has developed a reportable communicable



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disease as defined by the State Board of Health, except for life threatening diseases, which I/we agree to report immediately.

5. I/we agree that my/our child(ren) may not attend Sparkles! with any illness that threatens the health of other children, or that prevents their participation in the Center’s routine. I/we understand and agree that the Health Department regulations governing periods of infection will be enforced and I/we agree to abide by all Sparkles! illness policies set forth in writing or in the Parent Handbook. Specifically, I/we agree that our child(ren) may not attend Sparkles! if my/our child(ren) is/are vomiting, has/have diarrhea or a fever of 100 degrees either alone or in combination with other symptoms including a sore throat.
6. I/we agree that our child(ren) will obtain all age-appropriate immunizations as required by the Virginia Department of Health Services.
7. I/we understand that my/our child(ren) will be released only to authorized individuals. No child will be released to someone whose name is not on file. Unless additional names are provided in writing by parents, only the parents/guardians identified below are authorized individuals.
8. Sparkles! makes every effort to keep all children safe, however, accidents sometimes happen I/we agree for myself/ourselves and on behalf of my/our child(ren), hereby release and discharge Sparkles!, its partners, agents, employees and affiliates (“Released Parties”) from all claims, demands, damages, actions, causes of actions, suits, judgments and executions whatsoever, in law or equity, which I/we, the child(ren), our heirs, executors, assigns or administrators ever had, now has, or may have, or claim to have, against the Released Parties by reason of my/our child(ren)’s attendance at Sparkles! I/we agree, for myself/ourselves, my/our child(ren) and any other claimant that the Released Parties will not be liable and no claims will be made against the Released Parties if my/our child(ren) should suffer personal injury or death as a result of my/our child(ren)’s attendance at Sparkles!
9. I/we agree that Sparkles! has our permission for the child(ren) to take field trips within walking distance from the Sparkles! Center. Parents will be given prior notice of all field trips and will be asked to sign a Field Trip Permission slip for all field trips that require transportation. _____ (Initial)
10. I/we authorize Sparkles! to obtain immediate medical care for my/our child(ren) if any emergency occurs or if I/we cannot be contacted immediately. _____ (Initial)
11. I/we authorize Sparkles! to use photos and other recordings of my/our child(ren) for training and professional development and for promotions purposes. _____ (Initial)
12. I/we have read, and agree to abide by, the terms and conditions of the Sparkles! Parent’s Handbook and this Enrollment Agreement. I/we understand that Sparkles! reserves the right to change existing policies or introduce new policies immediately upon written notice.

Print Parent/Guardian(s) Name(s): _____

Parent/Guardian(s) Signature(s): _____ Date: _____
_____ Date: _____

For SPARKLES! _____ Date: _____

Director



At White Oaks Extended Care
SPARKLES AUTHORIZATIONS

1. SPARKLES LOCATION FOR AUTHORIZATIONS

- a. **Address: 6130 Shiplett Blvd., Burke**
- b. **Zip Code: 22015**
- c. **State: Virginia**

Signature of Parent/Guardian: _____ Date: _____

2. PERMISSIONS FOR EMERGENCY MEDICAL TREATMENT.

I authorize Sparkles to obtain all necessary emergency care for my child

Signature of Parent/Guardian: _____ Date: _____

3. ILLNESS.

In the event of an emergency or illness, I will make arrangements for my child to be picked up from Sparkles within one hour after I am notified.

Signature of Parent/Guardian: _____ Date: _____

4. PHOTOS

I authorize Sparkles to take and use photographs of my child for class projects, center display area, publicity, etc.

Signature of Parent/Guardian: _____ Date: _____



At White Oaks Extended Care
CHILD HISTORY

Child's Name: _____ Nickname _____ DOB _____

Every child is special and unique. In order for us to help to get to know your child and family, we need your help with this questionnaire. The ultimate goal is to be able to meet the needs of your child. Together we will become a great team.

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Please list all members of your family, including pets:

- 1- _____ Relationship: _____
- 2- _____ Relationship: _____
- 3- _____ Relationship: _____
- 4- _____ Relationship: _____
- 5- _____ Relationship: _____
- 6- _____ Relationship: _____

Child's and families favorite activities:

- 1- _____
- 2- _____
- 3- _____

Generally, how would you describe your child?

- 1- Physically: _____
- 2- Socially: _____
- 3- Emotionally: _____
- 4- Intellectually: _____

What other languages than English do you speak regularly at home?

- 1- _____
- 2- _____

What methods of discipline do you find the most effective?

The most ineffective?



At White Oaks Extended Care
CHILD HISTORY CONT...

Has your child been in day care, school or another peer group before?

- No
- Yes, Name: _____ Type: _____
Length of attendance: _____ Experience: _____

Are there particular areas in which your child needs special encouragement and support?

Does your child take a nap?

- No
- Yes, Mornings Afternoons

Is your child toilet trained?

- No
- Yes, does your child have any special word for toileting _____

Are there any foods your child may not or cannot eat (due to allergies, religion or customs, etc.)?

- No
- Yes, please list:
- 1- _____
- 2- _____
- 3- _____

Special Interest:

- Singing Painting Stories Trucks pets
- Dancing Other _____

Is there anything that your child is afraid of?

- 1- _____
- 2- _____
- 3- _____

Is there anything else that you think we should know to help us understand your child?



At White Oaks Extended Care

AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, hereby authorize any physician member of the
Department

(Parent or Guardian)

of Emergency Medicine or any member of the Medical Staff of Fairfax Hospital or Fair Oaks
Hospital, to render medical treatment, which in her/his judgment may be deemed necessary in
the care of _____.

(Child or Dependent)

Child's Date of Birth: _____ Last Tetanus Shot _____

Child's Allergies (if any): _____

Child's Doctor: _____ Phone: _____

Family Doctor: _____ Phone: _____

Medicines Child is taking: _____

Outstanding Medical History (e.g., Diabetes, Heart Disease, etc.) _____

Insurance Information

Insurance Company: _____

Identification #: _____ Policy #: _____

Subscriber's Name: _____ Phone: _____

Subscriber's Place of Employment: _____

Family Information

Mother's Name: _____ Father's Name: _____

Home Phone #: _____ Home Phone #: _____

Business Address: _____ Business Address: _____

Business Phone #: _____ Business Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Parent's Signatures



At White Oaks Extended Care

**RECURRING TRANSACTION ENROLLMENT FORM
FOR CREDIT CARD OR ELECTRONIC CHECKS**

DATE : _____ CHILD NAME: _____

NAME OF ACCOUNT PRINCIPAL:

First Name Last Name

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____
mm/dd/yy

TYPE OF CREDIT CARD:

- VISA
 MASTER CARD
 AMERICAN EXPRESS
 DISCOVERY
 OTHER _____

Please specify

ADDRESS WHERE YOU RECEIVED YOUR STATEMENTS

STREET: _____

CITY, STATE _____ ZIP CODE: _____

E-MAIL ADDRESS : _____

I Authorize Sparkles! Early Learning Academy and its affiliates to debit the credit card specified above accordingly with the charges incurred on my account.

Signature

Date