

WESTGATE CHILD CENTER
1609 GREAT FALLS STREET * MCLEAN * VIRGINIA 22101.
(703) 893 - 6372 * Fax 821 - 2126.
Hours of Operation: 7:00 AM to 6:30 PM

REGISTRATION FORM -

1. **Child's Name:** ----- **Date Admitted :**-----
Date of Birth: ___/___/____ **Sex: (Circle) - M or F**
2. **Mother's Name / (Guardian):** ----- **Cell Phone #** -----
Address: ----- **Home Phone # ()** -----
----- **E-Mail Address** -----
Employer & Work Address : ----- **Work Phone # ()**-----

3. **Father's Name / (Guardian):** ----- **Home Phone # ()** -----
Address: ----- **Cell Phone #** -----
Employer & Work Address : ----- **Work Phone No: ()** -----

4. **Person (s) having legal custody of child:** _____
5. **Child's Physician:** _____ **Phone # ()** _____ - _____
6. **Allergies to food and medication:** _____
7. **Chronic Physical problems or pertinent developmental information :** _____

8. **Name of 2 persons to contact if parents/ guardians listed above cannot be reached:** _____
- Name:** _____ **Phone No. : ()** _____ - _____
Address: _____
Relationship to child _____
- Name:** _____ **Phone No. : ()** _____ - _____
Address: _____
Relationship to child _____
9. **Do you authorize Westgate Child Center to allow the child to participate in duly authorized field trips when feasible.** _____
10. **If child attends another school/program, please provide its name :** _____

AGREEMENTS

- 1. Westgate Child Center agrees to notify the parent/guardian whenever the child becomes ill and the parent /guardian will arrange to have the child picked up as soon as possible if so required by the Center.
- 2. The parent/guardian authorizes the Center to obtain immediate medical care if any emergency occurs when he/she cannot be located immediately
- 3. Parent/guardian will inform the Center within 24 hours or next business day after his child or any member of the immediate household has developed any reportable communicable diseases.
- 4. For compliance with the I.R.S. requirements, WCC is required to compile racial/ethnic information :

You are kindly requested to please check one of the following :

Caucasian ----- Hispanic ----- Asian & Pacific Islander----- Am. Indian -----
White ----- Black ----- Racially mixed /Other -----

SIGNATURES

Parents or Guardian ----- Date -----

Administrator of Center ----- Date -----

Date Child Entered care : ----- Date Left Care : -----

**OFFICE USE ONLY
IDENTITY VERIFICATION**

Place of Birth : ----- Birth Date : -----

Birth Certificate Number : ----- Date Issued : -----

Other Form of Proof (Passport etc.) : -----
