



A Montessori Children's House

Summer Program Application 2009

Location: Broadlands Herndon Reston Westfields

I hereby make application for my son daughter

whose full name is _____

Age _____ Date of Birth _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Mother's Name _____

Father's Name _____

Local next of kin or person for emergency _____

Relationship to child _____ Phone _____

Address _____

Family Physician _____

Phone _____

| Contact Information | |
|---------------------|-------|
| Child's Home # | _____ |
| E-mail | _____ |
| Mother's Work # | _____ |
| Mother's Cell # | _____ |
| Father's Work # | _____ |
| Father's Cell # | _____ |
| Family Physician | _____ |
| Address | _____ |
| Phone | _____ |
| Emergency Contact | _____ |
| Address | _____ |
| Phone | _____ |

PHOTOGRAPHS Photographs may be taken of my child during the course of the program, on school grounds and on field trips for use in articles and information about the school. Yes No _____(initial)

COMPLIANCE POLICY I will pick-up my child as soon as possible in the event that The Boyd School calls to inform me that my child is ill. This is in compliance with state regulation. _____(initial)

TRANSPORTATION I hereby give permission for my child, _____ to be transported via the Williams Bus Line either to, from and/or on field trips during the duration of the program. _____(initial)

T-SHIRT INFORMATION The Boyd School provides your child's first summer shirt included in the fees. Additional T-shirts can be purchased for \$10.00.

Please indicate size:

- Child X-Small (2-4)
- Small (6-8)
- Medium (10-12)
- Large (14-16)

SWIMMING I authorize my child to participate in swimming activities during the Summer Program. Skill level of my child is _____ (initial)

AUTHORIZATION TO PICK-UP CHILD

Persons authorized to pick-up: _____

Persons NOT authorized to pick-up: _____

Appropriate legal paperwork is required if a parent is listed.

Student Name: _____

TERMS AND CONDITIONS OF ENROLLMENT

1. ____ (initial) The child and parents agree to abide by the rules and regulations set forth by the program for the health, safety and welfare of the child.
2. ____ (initial) All group or grade placements of pupils are solely at the discretion of the program director. Placement of a student is subject to change at any time.
3. ____ (initial) The program reserves the right to deny, cancel, sever or suspend a child's enrollment if deemed in the best interest of the child or school. The program will follow the discipline policy as outlined in The Boyd School Handbook. In the event a child is dismissed, all tuition payments already paid are not refundable.
4. ____ (initial) No refunds will be made for days missed due to illness, weather or holidays.
5. ____ (initial) If your child is not picked up on time, you will be charged overtime at the rate of \$2 per minute for the first 10 minutes, \$4 per minute for 11-20 minutes, and \$10 per minute 21+ minutes—based on the clock in the office.
6. ____ (initial) We understand the policies and procedures set forth in the above paragraphs and we are obligated to adhere to them.

SUMMER RATE SCHEDULE: (check below)

| Session | Theme | Full Day 9-3pm | Half Day 9-1pm | Early Care 8-9am | Late Care 3-5pm | Total |
|---------------------------|-------------------------|-------------------|-------------------|---------------------|--------------------|----------|
| Week #1 June 29-July 2 | Red, White & Blue | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #2 July 6-July 10 | Planting a Rainbow | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #3 July 13-July 17 | Dinosaur Rock | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #4 July 20-July 24 | Under the Big Top | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #5 July 27-July 31 | The Cat in the Hat | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #6 Aug 3-Aug 7 | Artists & Their Museums | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #7 Aug 10-Aug 14 | Space Training | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Week #8 Aug 17-Aug 21 | At the Zoo | \$268.50 | \$190.60 | \$50.00 | \$100.00 | _____ |
| Tuition Deposit | | | | | | \$250.00 |
| Total Tuition Due | | | | | | _____ |
| Tuition with 5% Discount* | | | | | | _____ |

*The deposit is non-refundable after close of business on **May 18, 2009**. Remaining tuition is due the first day of each week.

*Sign up for **any 4 weeks** and receive a **5% discount**

*In order to be released from further tuition obligation, the program requires a 30 day written notice of withdrawal. Notice of withdrawal must be received 30 days from the start of the week for which the child is enrolled.

Parent Signature Date

Parent Signature Date

Accepted By Date

| | | |
|--------------------|-----------------|-------|
| OFFICE USE: | Tuition Deposit | _____ |
| | Tuition Paid | _____ |

Emergency Health History 2009

Students Name: _____

Name (please print) _____

Home Address _____

Home Phone _____

SSN (optional) _____ Date of Birth _____ Sex _____

Father's Name _____

Work Address _____ Work Phone _____

Father's Beeper _____ Cell Phone _____

Mother's Name _____

Work Address _____ Work Phone _____

Mother's Beeper _____ Cell Phone _____

EMERGENCY INFORMATION

List two emergency contacts with different contact numbers in the event parents/guardian cannot be reached.

1. Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

2. Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

INSURANCE INFORMATION

Pediatrician/Physician _____ Phone _____

Dentist/Orthodontist _____ Phone _____

PARENT'S AUTHORIZATION

This emergency information and health history are correct so far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted on reverse of form. I, as parent/guardian, authorize The Boyd School Program personnel to seek emergency treatment as required and to transport my child to the appropriate facility in the event that urgent/emergency care is necessary. The hospital and its medical staff have my authorization to provide any treatment, which a physician deems necessary for the well being of my child. I understand that minor accidents or injuries will be treated on location and that I will be notified of any such treatment. I understand the specific medical information may be shared with program staff as it is deemed necessary.

Signature _____ Date _____

Students Name: _____

HEALTH HISTORY Which of the following has the participant had? *Check and give approximate dates.* Students Name: _____

Diseases

- Chicken Pox _____
- Measles _____
- German measles _____
- Mumps _____
- Asthma _____
- Hepatitis _____

Allergies

- Hay Fever _____
- Ivy Poisoning, etc. _____
- Insect Stings _____
- Penicillin _____
- Other drugs _____

Conditions

- Ear Infections _____
- Rheumatic Fever _____
- Convulsions _____
- Diabetes _____
- A.D.D. _____

Operations or serious injuries (incl. dates) _____

Chronic or recurring illness _____

Psychological problems _____

IMMUNIZATION HISTORY

NOTE: All Program participants are required to have completed Virginia School Health Form, signed and dated by a physician, and submitted at least one week prior to the participant's first session. Parents/Legal guardians of program participant applicants may fill this section indicating the dates of basic immunizations and MOST RECENT BOOSTER DOSES. You may call your physician for immunization information.

DPT Series _____ Booster _____ Tetanus Booster _____
Polio OPV (Sabin) _____ Booster _____ Tuberculin Test _____
Measles Vaccine (live) _____ MMR _____
Mumps Vaccine (live) _____ Haemophilus influenza B _____
German measles (Rubella) _____ Hepatitis B _____
Varicella (Chicken pox) _____ BCG _____
Other _____

RECOMMENDATIONS AND RESTRICTIONS

Special Diet _____

Special Medicine (name) _____ Is parent sending it? Yes No

Strenuous activity _____

Other _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION – Must be signed by a physician.

Diagnosis: _____ Symptoms/condition which requires administration of medication: _____

Medication Name: _____ Dosage to be given: _____

Time to be given: _____

If student is taking more than one medication, please list sequence in which medication are to be given: _____

Special instructions/action for the staff: _____

PARENT/GUARDIAN DECLARATION This health history is correct and complete as far as I know.

Parent's signature _____ Print name _____ Date _____

Physician signature _____ Print name _____ Date _____

*** Physician signatures on this form must be original. Faxed or copied signatures are unacceptable. ***