

# Bryant Early Learning Center

2709 Popkins Lane  
Alexandria, VA 22306  
(703) 765-0909

## **Statement of Philosophy and Goals**

The BEL Center uses a developmentally appropriate curriculum and a variety of approaches to teaching young children. We strive to provide:

Positive experiences that stimulate natural curiosity.

A safe, and nurturing environment where children learn through play.

Positive stimulation that encourages the use of the five senses.

Structured activities and social interaction with peers and staff that help develop a sound perception of the world around them.

Settings that allow the child to freely and comfortably express needs, develop self control, respect others, and most importantly, develop a positive self-image.

Spontaneous creativity that allows self-expression.

*It is our belief that shared experiences among children, parents, teachers and members of the community, educate and prepare children for entering school and equip them with skills needed to thrive throughout life.*



Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell phone#: \_\_\_\_\_

Other parent/guardian contact: \_\_\_\_\_

Names and ages of other children in the home:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place a check next to any of the following that have happened to you or any immediate family members in your household in the last 2 years.

- |   |  |
|---|--|
| <input type="checkbox"/> Death of a Spouse/Partner/Close friend | <input type="checkbox"/> Marriage        |
| <input type="checkbox"/> Divorce                                | <input type="checkbox"/> Pregnancy       |
| <input type="checkbox"/> Gaining a New Family Member            | <input type="checkbox"/> Health status   |
| <input type="checkbox"/> Separation                             | <input type="checkbox"/> Victim of crime |
| <input type="checkbox"/> Death of a Close Family Member         |  |

Have any unusual circumstances taken place in your family recently?

Yes  No  If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's reaction: \_\_\_\_\_

Have there been any changes in your child's routine? Yes  No  If yes, please describe:

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**Education of Family**

Please describe participation in adult education, college, vocational training and anticipated date of completion of education program.

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**Employment**

Please describe your current work situation. What kind of work do you do?

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Do more family members need employment or longer work hours? Yes   
No

If yes, please explain:

Is there need for job training? Yes  No

If yes, please explain:

In case of unemployment, what are the reasons?

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**Confidential and Family Information**

Bryant Early Learning Center asks that you provide the following information so that we can know what your child and family needs are. *All information will be strictly confidential to be used only as necessary the purpose of providing an appropriate learning and care environment.*

Person providing information:

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Your relationship to child:

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Primary Language spoken in the home:

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Other languages spoken in the home:

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If parents/ guardians are separated or divorced please describe the custody arrangement.

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Do you have legal documentation of custody arrangement? Yes  No

Describe your child's relationship with non-custodial parent(s):

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Is child adopted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, does the child know?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the child in foster care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please list members in household where child resides.

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
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Please list the names of others who care for the child (grandmother, aunt, etc.):

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Please check if the family is currently receiving other services:

TANF/ WELFARE	<input type="checkbox"/>	MEDICARD	<input type="checkbox"/>	FOOD STAMPS	<input type="checkbox"/>
SSI	<input type="checkbox"/>	UNEMPLOYMENT	<input type="checkbox"/>	WIC	<input type="checkbox"/>

Other: \_\_\_\_\_

Do you object to your child celebrating holidays, or other activities that may be of religious nature? Yes  No

If yes, please explain.

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**USDA**  
Child and Adult Care Food Program

In order for the Bryant Early Learning center to comply with the CACFP program, we need to collect information about your child's expected schedule on a regular basis. Please provide the following information:

\_\_\_\_\_ Age or DOB \_\_\_\_\_ is enrolled at:  
Name of Child

Name of Center \_\_\_\_\_ Start Date \_\_\_\_\_

Normal hours in care: from \_\_\_\_\_ to \_\_\_\_\_

*What will be your child's normal days in care? (check all that apply)*

Monday  Tuesday  Wednesday  Thursday  Friday

*Please explain any unusual Circumstances related to child's attendance at the center:*

\_\_\_\_\_  
\_\_\_\_\_

*For which meals do you expect your child to be present on a daily basis?*

Breakfast (your child needs to arrive before 8:30 in order to participate in breakfast.)

Lunch

Afternoon snack

Please check here if your child is an infant who eats on demand.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

For Center use only:

Participant Withdrew on \_\_\_\_\_  
(Date)

**Child Information and Intake Form**

**General**

Has your child been in a child-care setting prior to coming to the center?  
Yes  No

If so, what type: home day care provider  center

Does your child separate easily from you? Yes  No

What is his/ her typical response?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child use any special words or expressions (such as “wee wee” for urine) which may not be understood by an outsider? Yes  No   
Please explain: \_\_\_\_\_

Does your child have any particular fears? Yes  No   
Please list them: \_\_\_\_\_

**Sleeping** ( ages 2.5 and older)

Time and length of naps:  
\_\_\_\_\_

What time does your child go to bed in the evening?  
\_\_\_\_\_

What time does he/she get up in the morning? \_\_\_\_\_

Does he/she have sleeping problems? Yes  No   
If yes, please explain:  
\_\_\_\_\_

Does your child usually cry when going to sleep? Yes  No   
Does he/ she wet the bed when sleeping? Yes  No

Other Comments: \_\_\_\_\_

**Eating**

Favorite foods: \_\_\_\_\_

Does your child have any eating problems? Yes  No

If yes, please explain: \_\_\_\_\_

**Elimination**

Is your child toilet trained? Yes  No  In process

Does your child need adult assistance? Yes  No

If yes, please explain: \_\_\_\_\_

Other Comments: \_\_\_\_\_

**Speech**

Does child have any speech difficulties? Yes  No

If yes, please explain: \_\_\_\_\_

**Interaction**

Does child prefer to play alone  with adults  or with other children

Favorite toys: \_\_\_\_\_

Favorite books: \_\_\_\_\_

How would you describe your child's general disposition? (Happy, Outgoing, Quiet, Shy, etc.) \_\_\_\_\_

Does he/she generally get along with other children in a group setting? Yes  No

\_\_\_\_\_  
\_\_\_\_\_

How does he/she generally react to unfamiliar adults/ settings? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does he/she play well with other children? Yes  No   
If so, what is the interaction like?

\_\_\_\_\_  
\_\_\_\_\_

**Behavior**

Does your child have temper tantrums? Yes  No   
What helps your child when he/she is upset?

\_\_\_\_\_

What activities does your child especially enjoy?

\_\_\_\_\_

Other Comments: \_\_\_\_\_

**Health and Medical Information**

How would you describe your child's health? Very good  Good   
Poor

Please explain any problems: \_\_\_\_\_

Has he/she had any serious operation or illnesses? Yes  No   
If yes, please explain and give dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child take medicine daily on a regular basis? Yes  No  If so,  
what medication and why? \_\_\_\_\_

\_\_\_\_\_

Do you have any special concerns about your child's health? Yes  No   
If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

Does your child have health insurance? Yes  No

**Additional Information**

(children 6 weeks to 2.5 years only)

*Please provide additional information about your child.*

**Infant:** 6 wks-12 mos.

Child's name: \_\_\_\_\_

Please note napping pattern:

AM Time \_\_\_\_\_ PM Time \_\_\_\_\_  
Length \_\_\_\_\_ Length \_\_\_\_\_

Diapering:

Please note the type of lotion, cream, and/or powder that you regularly use:

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–

Does your child have frequent diaper rashes?

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Feeding schedule: List times formula given:

AM \_\_\_\_\_ PM \_\_\_\_\_

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What type of formula does your child use?

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Other comments:

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**Toddlers:** 12 months – 2 ½ years

Child's name: \_\_\_\_\_

Is your child accustomed to feeding him/herself?

Yes  No

Does child use a spoon?

Yes  No

Does child continue to take a bottle?

Yes  No

If yes, when? \_\_\_\_\_

Does he/she use a pacifier?

Yes  No

When? \_\_\_\_\_







Ethnic background White Black Hispanic Asian American  
American Indian Other

Sex Male Female  
Marital status Single Married Single parent Separated  
Divorced Widowed

Veteran VIP/VIEW Health Insurance Legally disabled  
Working Not Working Self Employed

Years of school completed \_\_\_\_\_ *Please see reverse side*

4. Name \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Social Security number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-

Ethnic background White Black Hispanic Asian American  
American Indian Other

Sex Male Female  
Marital status Single Married Single parent Separated

Divorced Widowed  
Veteran VIP/VIEW Health Insurance Legally disabled  
Working Not Working Self Employed

Years of school completed \_\_\_\_\_

5. Name \_\_\_\_\_  
First Middle Last

Date of birth: \_\_\_\_\_ Social Security number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-

Ethnic background White Black Hispanic Asian American  
American Indian Other

Sex Male Female  
Marital status Single Married Single parent Separated

Divorced Widowed  
Veteran VIP/VIEW Health Insurance Legally disabled  
Working Not Working Self Employed

Years of school completed \_\_\_\_\_



**Emergency Form**

**THIS FORM MUST BE COMPLETED PRIOR TO YOUR CHILD'S FIRST DAY AT THE CENTER**

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_ Home  
phone \_\_\_\_\_

**PARENTS/ GUARDIANS**

Father's Name \_\_\_\_\_ Home phone  
\_\_\_\_\_

Home Address  
\_\_\_\_\_

Placed Employed \_\_\_\_\_ Work Phone  
\_\_\_\_\_

Work Address  
\_\_\_\_\_

Mother's Name \_\_\_\_\_ Home phone  
\_\_\_\_\_

Home Address  
\_\_\_\_\_

Placed Employed \_\_\_\_\_ Work Phone  
\_\_\_\_\_

Work Address  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Name of Child's physician \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contacts: You must list someone other than yourself and the child's other parent. Emergency contacts must live/work within a 30 minute drive of the BEL Center.**

1. Name \_\_\_\_\_ Relation to child  
\_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relation to child  
\_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

Persons authorized to pick up  
child: \_\_\_\_\_

Persons **NOT AUTHORIZED** to **VISIT** or **PICK UP** child:  
\_\_\_\_\_

Does your child have **allergies** to any medicine?  
\_\_\_\_\_

Does your child have **allergies** to any food?

Other **allergies** (i.e. Pollen, bee stings,  
dogs/cats) \_\_\_\_\_

**I AUTHORIZE THE BRYANT EARLY LEARNING CENTER TO OBTAIN IMMEDIATE  
MEDICAL ATTENTION IF AN EMERGENCY OCCURS AND I, AS A PARENT/ GUARDIAN  
CANNOT BE IMMEDIATELY NOTIFIED.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Bryant Early Learning Center

### Acknowledgement of Health Status/Special Health Needs Form

This form is to be filled out and submitted by parents whose children have a unique health status which requires special care (i.e. children with asthma who use nubulizers, children with allergies who keep epipen onsite).

Child's Name: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_  
Person filling out this form: \_\_\_\_\_  
Date: \_\_\_\_\_

Please describe in detail your child's unique health status and special health needs of which the staff need to be aware:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Parent's signature: \_\_\_\_\_

Staff signature: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note to staff: When the child transitions to the next classroom, ensure that this form is presented to the staff in the new room and signed off on by those staff members.

## **Parent Agreement**

### **FEES**

All tuition and fees are due in **advance, weekly, bi-weekly or monthly**. A non-refundable registration fee of \$50.00 must accompany this application for enrollment. A \$50.00 registration fee is also collected every September.

By enrolling your child you consent to pay 52 weeks of annual tuition. This will be paid at the rate of \$ \_\_\_\_\_ every **week/2 weeks/month** (please circle one).

**Note: this tuition will change as your child transitions to another tuition level. Please see Parent Handbook for more detail. Parents participating in the Child Care Assistance Program with Office for Children will notice a change in fee when they complete their yearly re-certification with that agency.**

You agree to notify the director if payment cannot be made on due date. Non-payment of tuition may result in late fee and/or disenrollment of your child from the center.

**FIELD TRIPS**

I as a parent/guardian, give authorization for my child to participate in field trips.

Yes  No

**MEDICAL**

Upon notification by the center that my child is ill, I will pick my child up or make arrangements to have him/her picked up within the hour notified.

I give permission for my child to be screened during the health screening held at the center for speech, hearing, development, dental and vision at no extra cost me.

Signature: \_\_\_\_\_  
*Parent/Guardian*

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Center Director

Date: \_\_\_\_\_