

C.A.P.

Commonwealth After-School Program

700 Commonwealth Ave.
Alexandria, VA 22301
ToniAfterSchool@gmail.com

APPLICATION FOR ADMISSION

Name of Student: _____

Prefers to be called: _____ Birth Date: _____ Sex: _____

Complete Home Address: _____

Previous Child Care Programs attended (required by state law): _____

PARENTS/GUARDIAN

Parent/Guardian: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Home Address (if different from child): _____

Parent/Guardian: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Home Address (if different from child): _____

Persons Having Legal Custody of Student: _____

Address: _____ Phone: _____

OTHER INFORMATION

When would you like your child to start at C.A.P.? _____

Program days needed: *(please circle the days needed below)*

Monday	Tuesday	Wednesday	Thursday	Friday	Every Day
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Chronic Physical Problems/Allergies/Pertinent Developmental Information/Special Accommodations Needed: _____

How did you hear about C.A.P.? _____

*****A \$75.00 application fee must accompany each application*****

SIGNATURES

Parent or Guardian: _____ Date: _____

Director: _____ Date: _____

Date Student Admitted: _____

PROOF OF IDENTITY AND AGE OF STUDENT

Office Use Only

Place of Birth: _____ Date of Birth: _____

Birth Certificate Number: _____ Date Issued: _____

Other Form of Proof: _____

Verified By: _____ Date: _____