5587 Guinea Rd., Fairfax, VA 22032
(703)764-0800

Attention Parents:

In order for World Karate / After School Martial Arts to comply with the State of Virginia licensing requirements, please read and become aware of the following information.

World Karate / After School Martial Arts is NOT licensed by the State as a childcare ,day care or any other kind of licensed childcare facility. We are only a martial arts centerthat provide school tutoring of "child care". Our current curriculum includes martial artsclasses beginning after school and ending in the evening.

World Karate has 18 years experience (since 1984) and has trained thousands of students. Please be advised t hat all students of World Karate may come and go, to and from classes or the premises as they please with permission from parents.

I have read, understand and approve of this information and facility.

Parent:

Children:

Date:

PERMISSION TO RIDE FORM

APPLICANT INFORMATION

School Name:

I (We) hereby grant permission for _____to ride to the after school program located at _____ on the following days.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Students will be traveling in t the following manner:

☐ School Bus

☐ Private Passenger Vehicle

☐ Commercial Transportation Carrier

☐ Other _____

1) I authorize after school program representatives to obtain medical treatment for my child in case of serious illness or injury and agree to pay for such treatment.

2) I understand that the certified after school program employee who usually dispenses medications may or may not be present during the trip. Medications will be dispensed by a responsible staff member.

3) I have documented below all the precautions and instructions regarding my child.

_____

_____

_____

Date:

Signature of parent / Guardian:

Home Phone:	Mobile:
Work Number:	E-mail:
Alternate Emergency Contact::	
Home Phone:	Mobile:
Work Number:	E-mail:

DIRECTOR'S USE ONLY-Enrollment Date: _____

PARENT AND CHILD'S IDENTFICATION RECORD

CHILD'S INFORMATION		
Child's Full Legal Name:		
Child's Preferred Name:	School:	
Current address:		
City:	State:	ZIP Code:
Who has legal custody?		Relationship:
Address:		Telephone:

MOTHER'S INFORMATION		
Name:		E-mail:
Home Address:	ZIP:	Mobile:
Place of Employment:		Telephone:
Address:		ZIP Code:

FATHER'S INFORMATION		
Name:		E-mail:
Home Address:	ZIP:	Mobile:
Place of Employment:		Telephone:
Address:		ZIP Code:

OTHER HOUSEHOLD MEMBERS
Adults:
Children and ages:

RELEASE FORM		
The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s). The following people are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent(s) or legal guardian(s) cannot be reached.		
Name:		Telephone:
Address:	City:	ZIP Code:
Name:		Telephone:
Address:	City:	ZIP Code:

HEALTH AND DENTAL	
Child's physician/ health resource:	Telephone:
Address:	
Child's Dentist:	Telephone:
Address:	
List all identifying scars, birthmarks, skin discolorations:	
Special needs of a child	
Child's habits, fears, etc.	
Previous preschool or group experiences (include dates):	

PERMISSION STATEMENT
I give permission to consult the child's physician resource listed above in case of an emergency if I/we cannot be reached.
Signature of Custodial Parent or Legal Guardian:

PARENTS ACKNOWLEDGEMENT OF RULES AND REGULATIONS

I hereby acknowledge receipt of the Center's After school Rules and Regulations and policies. I further attest that I have reviewed the Discipline Procedures and Policies with my child(ren) and by signature below we agree to abide by these rules and regulations.

I am aware of and agree to:

The Center's drop off and pick up times

Sick Child Policy

Attendance Policy

Snack Policy

No firearms, No alcohol and No Smoking Policy

_____
Child's Name

_____
Signature of Parent or Guardian (circle one)

Address:		
City:	State:	ZIP Code:
Home Phone:	Mobile:	
Work Number:	E-mail:	

RELEASE FOR EMERGENCY CARE

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child

_____in the event of an emergency at which time I cannot be reached.

I give consent to transport by ambulance if situation warrants it.

_____ _____

Family Physician's Name/ Health Care Resource | Telephone Number

Allergies:		
Date of last DPT or tetanus:		
Insurance Company covering child:		
Policy Number:	Group No.	
SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN:		
Home Phone Number:	Work Phone Number:	Date:
Mobile:	E-mail:	
EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Mobile:	Relationship:	