Washington International Academy
6408 Edsall Rd. Alexandria, VA 22312
PH: (703) 941-6977 | FAX: (703) 941-6279
E-MAIL: office@wiaschool.org

after-school Student Registration form

APPLICANT INFORMATION

Last:	First:	M.I.
DOB:	Phone:	Cell Phone:
Address:		Male ☐ Female ☐
City:	State:	ZIP Code:

PARENT OR GUARDIAN INFORMATION

Enrolling Parent

☐ Resides With ☐ Does not reside with	Relationship:	☐ Mother ☐ Stepmother	☐ Father ☐ Stepfather	☐ Legal Guardian ☐ Other (specify) ___________
Last		First		Middle
Home Phone:		Work Phone:		Cell Phone:
E-mail Address:				

Other Parent

☐ Resides With ☐ Does not reside with	Relationship:	☐ Mother ☐ Stepmother	☐ Father ☐ Stepfather	☐ Legal Guardian ☐ Other (specify) ___________
Last		First		Middle
Home Phone:		Work Phone:		Cell Phone:
E-mail Address:				

EMERGENCY CONTACT

Name:	Relationship:	Best # to Call:
Name:	Relationship:	Best # to Call:
Name:	Relationship:	Best # to Call:

PAYMENT PLAN

4-5 Days

- $300 (all grades)
- $190 for each additional child
- ***Payment Due on 1st of every month***

2-3 Days

- $150 (all grades)
- $120 for each additional child

Payment Due on 1st of every month

SIGNATURES

I certify that all the information on this student registration form is true and correct to the best of my knowledge and belief. I understand that the information in this application and any supporting documents submitted will be confidential and only shared with relevant school personnel, as needed. I agree to all the terms and conditions for the afterschool program.

Name:	Relationship to Student:
Signature:	Date:

TO BE COMPLETED BY SCHOOL STAFF ONLY

Payment Type:	☐ Cash	☐ Credit Card	☐ Check # ___________	☐ Money Order # _______
Application Received:		Received By:		
Comments:				

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STUDENT EMERGENCY HEALTHCARE INFORMATION

Last:	First:	Grade:

MEDICAL ISSUES & ALLERGIES

Please list any allergies or other medical issues, including restrictions that need to be made:

MEDICATIONS

Will an adult need to administer any medication during the day? ☐ NO ☐ YES (If yes, sign below)

NOTE: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with the child's name and instructions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream will be administered to any child unless it is prepared in accordance to these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by WIA. I have provided the medication, clearly labeled and with clear instructions, to the School.

Name:	Relationship to Student:
Signature:	Date:

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, WIA, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name:	Relationship to Student:
Signature:	Date:

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In addition to the parents or legal guardians, you may list up to three other adults who are authorized to pick up your child. Any adult, including the parents or legal guardians, who come to pick up the child, must show a valid identification.

AFTER-SCHOOL PICK-UP AUTHORIZATION FORM

Last:	First:	M.I.	
DOB:	Phone:	Male ☐	Female ☐

Please List the Number of Siblings in the After-School Program:

1	Name:		AGE:	Male ☐	Female ☐
2	Name:		AGE:	Male ☐	Female ☐
3	Name:		AGE:	Male ☐	Female ☐
4	Name:		AGE:	Male ☐	Female ☐
5	Name:		AGE:	Male ☐	Female ☐

AUTHORIZED PICK-UP ALTERNATE 1

Last	First	Relationship:	
Home Phone:	Work Phone:	Cell Phone:	
Address:		Male ☐	Female ☐
City:	State:	ZIP Code:	

AUTHORIZED PICK-UP ALTERNATE 2

Last	First	Relationship:	
Home Phone:	Work Phone:	Cell Phone:	
Address:		Male ☐	Female ☐
City:	State:	ZIP Code:	

AUTHORIZED PICK-UP ALTERNATE 3

Last	First	Relationship:	
Home Phone:	Work Phone:	Cell Phone:	
Address:		Male ☐	Female ☐
City:	State:	ZIP Code:	

PARENT/ LEGAL GUARDIAN AUTHORIZATION

I authorize the individuals named above to pick-up the student named above from school. I understand that a driver's license or government issued ID will be required to verify the identity of the authorized pick-up alternate.

Name:	Relationship to Student:
Signature:	Date: