

Child's Name _____ Date of Birth _____

Place of Birth _____ Sex: M ___ F ___ Child's age as of December 2, 2009 _____

Address _____

City, Zip _____ Home Phone _____

Family e-mail _____

Father's Name _____ Work Phone _____ Cell Phone _____

Employer _____ Position _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Employer _____ Position _____

Primary language spoken at home: _____

Names and ages of siblings _____

Does your child have a nickname? _____ How did you hear about us? _____

What church do you attend? [] None [] PCC [] Other _____

Does your child have any allergy or special need? _____

I want to register my child for the following program:

4-YEAR OLDS
(Age 4 by Dec. 2)

- [] 5-Hr. Program
(9 am-2 pm)
- [] 3.5-Hr. Program
(9 am-12:30 pm)

- [] 5-Day
- [] 4-Day (T W Th F)
- [] 3-Day (M W F)
- [] 2-Day (T TH)

3-YEAR OLDS
(Age 3 by Dec.2)

- [] 5-Hr. Program
(9 am-2 pm)
- [] 3.5-Hr. Program
(9 am-12:30 pm)

- [] 5-Day
- [] 4-Day (T W Th F)
- [] 3-Day (M W F)
- [] 2-Day (T Th)

2-YEAR OLDS
(Age 2 by Sept. 1)

- [] 3-Day (M W F)
- [] 2-Day (T Th)
(9 am-12:30 pm)



I understand the registration fee is non-refundable.

Parent's Signature _____

Date _____

FOR SCHOOL USE ONLY
Enrollment Fee _____
Date: _____
ck #: _____

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

Peninsula Community Church Preschool . This Child Care Center/School provides a program which extends from 9 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 2:00 a.m./p.m) , 5 _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

Dental: _____

Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY (HAEMOPHILUS B))	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
____ Communicable TB disease not present.

I have have not reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

Physician Physician's Assistant Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.



Peninsula Community Church Preschool Parent Admission Agreement 2010-2011

1. Basic Services

Peninsula Community Church Preschool provides a safe and well-rounded program of education for children ages 2 – 5 years old. We present an academic program appropriate for the ages of the children in order to prepare them for kindergarten. Each class provides a daily schedule of circle time, teacher-directed activities, individual and group play, a mid-morning snack, and lunch time. Lunch and snack are provided by the family each school day. Chapel time consists of age-appropriate songs and stories that communicate God's love for all of us.

2. Optional Services

a. Early Care is offered from 8-8:30, 8:30-9 am at an additional charge of \$3.00/half hour. Early Bird care is limited to 6 children each morning. This optional service needs to be pre-arranged on the Early Care sign-in sheet.

b. Stay and Play is offered from 12:30 – 1, 1-1:30 and 1:30–2. An additional fee of \$3.00 is charged per half hour. Sign-ups are taken each morning. This is offered to children that are FULLY potty trained ONLY. **A late fee of \$1.00 per minute will be charged to your account after the parent's designated pick-up time.** If there is low enrollment, Stay and Play may be modified. Pre-paid hours for extended care are available in the preschool office. If you choose not to pre-pay, payment is due when you sign up your child that day. Early Care and Stay and Play may be cancelled at any time due to unforeseen reasons or low enrollment. A sign will be posted to notify the parents of any cancellation.

3. Payment Provisions

a. A non-refundable registration fee of \$100, (\$75.00 for returning families) will be paid to the school before the child's first day of school. This registration fee must be paid each new school year or before the child attends school to secure his/her school enrollment.

b. Tuition is based on a 9 ½ month school year from September through ½ of June. Parents will pay the monthly tuition agreed upon by the parent and the school for the child to attend two, three, four, or five days each week, 3 hours, 3.5 hours or 5 hours a day. This payment is due on the first calendar day of each month. The initial payment for fall is due by July 10th.

c. The security deposit is equal to ½ of June. This fee will be paid with the first month tuition. This is the child's tuition payment for the month of June 2010. This is a non-refundable fee; however, if a family leaves PCC Preschool before the end of the school year, this fee may be applied to the last month of attendance if proper one month notice is given. This fee will be forfeited if the school is not notified.

d. An earthquake kit has been pre-ordered for each child. This payment is included with your initial registration fee.

e. Late payments: If the school has not received payment from the parent or guardian for the monthly tuition before the 10th calendar day of each month, a \$15.00 late fee will be applied to the family account for each child enrolled in the school and each week's payment is not received.

f. Absence Policy: The monthly tuition is payable each month of the school year regardless of whether the child is absent for any reason, including, but not limited to illness, vacation, or school holidays. Please notify the office by phone if your child is absent for any reason.

g. Refunds: If the child cannot remain in school for a full school year, please give the school a one-month prior written notice. If you do not give the school a one-month written notice, your security deposit is forfeited.

4. **Holidays**

The school generally follows the holiday schedule of the Palos Verdes Peninsula School District. There will be two staff development days and staff meetings that will affect our days and hours during the school year. The school holiday calendar will be given to the parents in August or on your child's first day of school.

5. **Termination Condition**

a. The school may immediately terminate a child's enrollment upon notice to the parent of such termination, if any of the following conditions arise:

1. In the sole judgment of the school director, a child's behavior threatens the physical or mental health or well being of one or more of the other children at the school.
2. In the sole judgment of the school director, any parent, in any way prevents the school or staff members from performing its/their duties in a satisfactory manner.
3. In the sole judgment of the school director, the school's program does not meet the individual needs of the child.
4. In the sole judgment of the school director, the child's non-compliance with the rules would endanger his/her safety.
5. In the sole judgment of the school director, any parent or guardian who exceeds one month delinquency of any payment to the school.

If the school terminates the child's enrollment pursuant to the paragraphs above, the school will refund the security deposit; and if such termination occurs mid-month, a portion of the monthly tuition paid by the parent will be pro-rated on a daily basis for the remainder of the month.

6. **Terms:** This agreement shall be in effect for the school year of 2009 - 2010 or until the child is withdrawn from the school by the parent, unless terminated sooner in accordance with the provisions of this agreement.

7. **Waiver of Compliance:** No right under this agreement shall be waived (lost) merely by delaying or failing to exercise it.

8. **State Rights:** The Department of Social Services or any agency authorized by it, shall have the right and authority to interview children attending school and/or the school staff and to audit a child's or school's records without notice or prior consent, to observe the physical condition of children attending school and to have a licensed medical professional physically examine the school children, as part of the Department's regulation of a licensed day care center. The parent acknowledges and understands such right.

The signature below indicates that the Parent/Guardian has read the provisions of the Admission Agreement and enters into this agreement voluntarily. **Please sign and return this form with all paperwork.**

Print Name of Child(ren) Date

Parents/Guardians Name Date

Parents/Guardians Signature Date

School Director Date

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

_____ HOME ADDRESS

HOME PHONE
()

WORK PHONE
()

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL
 OTHER
 EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

LIC 995 (9/08)

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME		
ADDRESS		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
(PRINT THE NAME OF THE CHILD)	
(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	
(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)



Loving, Learning, Sharing, and Caring!

Dear Parents,

We will be taking pictures of your children throughout the school year. Many of these pictures are group shots. This is a great way for us to keep a visual record of the school year as well as displaying for advertising purposes.

Please check one:

I give permission for images of my child to be used in promotion of the Peninsula Community Church Preschool. This includes flyers, newsletters, scrapbook and the Peninsula Community Church website.

I do not give permission for my child's photo to be displayed for promotional purposes.

Name of Child: _____

Parent Name: _____

Parent signature: _____

Date: _____

Please list any restrictions that you may have.

**PLEASE RETURN THIS FORM WITH YOUR
1st Month Payment and PAPERWORK**

T-Shirt Order Form (FOR NEW STUDENTS ONLY)

Your 1st month tuition payment includes a FREE t-shirt for your child. Additional t-shirts are available in the pre-school office for \$5.

The t-shirts will be given out to your child's teacher when we have received your 1st month's tuition and this form.

Please indicate below the size and your child's first & last name

Youth XS (2-4)

Youth S (6-8)

Print child's first and last name

OFFICE USE ONLY: *Yes; I received my child's t-shirt. Parent initials:* _____

Date: _____ Order filled by: _____

EARTHQUAKE KIT

We have pre-ordered Earthquake kits for each child. The cost of the kit is included in your initial registration fee.

The kit includes: 3 /8.5oz boxes of water

A solar blanket

Wet naps

2400 calorie cinnamon/apple food bar*

12 hr. light stick

Please send a family photo and a letter to your child to include in their kit. Thank You!

*The food bar is safe for vegetarians and anyone allergic to nut oils.