

# RJ's Preschool Academy

## 2011-2012 Enrollment form



**KRAY & JOAN**  
**Kroc**  
 CORPS COMMUNITY CENTER  
 SAN DIEGO

### HOW DID YOU HEAR ABOUT RJ'S PRESCHOOL ACADEMY?

- FAMILY/FRIEND
- NEWSPAPER
- ONLINE SEARCH
- KROCCENTER.ORG
- MAIL
- COMMUNITY EVENT
- FLYER
- TV
- RADIO
- FACEBOOK
- MAGAZINE
- SAN DIEGO FAMILY MAG
- OTHER \_\_\_\_\_

### ADDITIONAL INFORMATION

This helps us develop quality services and programming to better serve our local community.

#### 1. WHAT PROGRAMS INTEREST YOU MOST?

- AQUATICS
- COMPUTER
- DANCE
- FITNESS
- VISUAL ARTS
- DAY CAMP
- MUSIC
- SPORTS
- AFTER-SCHOOL
- PERFORMING ARTS
- ICE SKATING
- ICE HOCKEY
- ROCK WALL
- SKATEBOARDING
- CHURCH
- FAMILY SERVICES
- PRESCHOOL
- RECOVERY
- OTHER \_\_\_\_\_

#### 2. HOUSEHOLD INCOME

- UNDER \$10,000
- \$10,000-24,999
- \$25,000-49,999
- \$50,000-74,999
- \$75,000-99,999
- OVER \$100,000
- DECLINE TO STATE

#### 3. HOUSEHOLD ETHNICITY

- WHITE/CAUCASIAN
- AFRICAN-AMERICAN
- HISPANIC/LATINO
- ASIAN/PACIFIC ISLANDER
- SOMALI
- NATIVE AMERICAN
- OTHER \_\_\_\_\_
- DECLINE TO STATE

#### 4. ARE YOU INTERESTED IN VOLUNTEERING?

- YES
- NO

INTERESTS/SKILLS:

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### (PLEASE PRINT)

#### STUDENT INFORMATION

CHILD'S FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ NAME CALLED \_\_\_\_\_

GENDER  MALE  FEMALE BIRTHDATE \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

FAMILY EMAIL \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_

MOM'S NAME (FIRST, LAST) \_\_\_\_\_ CELL ( ) \_\_\_\_\_

MOM'S BUSINESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

DAD'S NAME (FIRST, LAST) \_\_\_\_\_ CELL ( ) \_\_\_\_\_

DAD'S BUSINESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

GUARDIAN'S/NANNY'S NAME \_\_\_\_\_ CELL ( ) \_\_\_\_\_

GUARDIAN'S/NANNY'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

*(Note: if guardian's address is different from child's, please submit documents concerning any custody arrangements)*

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

#### EMERGENCY CONTACTS

Give names of persons to call if parents/guardians cannot be reached. I hereby authorize RJ Academy Preschool to disclose information, and/or allow my child to leave the facility with only the following people.

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ CELL ( ) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ CELL ( ) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ CELL ( ) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

#### MEDICAL EMERGENCY

In the event of a medical emergency, our policy is to contact our parents first. If we cannot reach you, we will try to contact any others you have designated. In the event that we are unable to contact you or your designated representative(s), or if the medical emergency warrants immediate response, we will act, on your behalf and in the best interest of your child. I authorize the facility director or person in charge to take my child to:

HOSPITAL \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

I give consent for this facility to secure all medical care for my child listed above.

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## GENERAL INFORMATION :

### NAMES AND AGES OF CHILD'S SIBLINGS:

NAME AGE NAME AGE

NAME AGE NAME AGE

CHURCH CURRENTLY ATTENDING  NONE:

HAS YOUR CHILD ATTENDED A PREVIOUS PRESCHOOL/CHILD CARE PROGRAM?  YES  NO

IF YES, NAME OF SCHOOL?  FULL -TIME  PART-TIME

WHAT ARE YOUR CHILD'S FAVORITE TOYS? ACTIVITIES?

WHAT SCHOOL WILL YOUR CHILD BE ATTENDING FOR KINDERGARTEN?

WHAT IS YOUR CHILD'S TEMPERAMENT?  FRIENDLY  SHY  ENERGETIC  AGGRESSIVE  WITHDRAWN

HOW DOES HE / SHE GET ALONG WITH OTHER CHILDREN?

DOES YOUR CHILD HAVE ANY FEARS?

IS THERE ANYTHING IN PARTICULAR THAT MIGHT ANGER OR UPSET YOUR CHILD?

HOW DOES YOUR CHILD DEMONSTRATE ANGER? FRUSTRATION?

WHAT DISCIPLINE TECHNIQUES / STRATEGIES DO YOU FIND TO BE MOST EFFECTIVE WITH YOUR CHILD?

IS YOUR CHILD STILL IN:  DIAPERS  PULL-UPS  IN THE PROCESS OF TOILET TRAINING  FULLY TOILET TRAINED

DOES YOUR CHILD HAVE ANY HAND PREFERENCE YET?  LEFT  RIGHT

WHAT DO YOU EXPECT YOUR CHILD TO GAIN FROM HIS/HER PRESCHOOL EXPERIENCE THIS YEAR?

ANY ADDITIONAL INFORMATION WE SHOULD KNOW THAT WILL HELP US IN WORKING WITH YOUR CHILD

## HEALTH INFORMATION

HAS YOUR CHILD HAD:  
 RUBELLA  ROSEOLA  MUMPS  CHICKEN POX

ANY CHRONIC ILLNESSES /HOSPITALIZATIONS / INJURIES

DOES YOUR CHILD HAVE ANY FOOD ALLERGIES?

ANY SPECIAL DIETARY NEEDS?

ANY PHYSICAL DISABILITIES:

ANY LONG TERM MEDICATIONS:

ANY ALLERGIES (FOOD/PET/MEDICINE): *(If there are food allergies, please contact the preschool office for additional paperwork)*

HAS YOUR CHILD HAD A HEARING, SPEECH OR DEVELOPMENTAL SCREENING? IF SO, PLEASE SHARE OUTCOME  
 YES  NO

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS?  YES  NO

## CHILD PHYSICIAN

*(if different from medical emergency contact)*

NAME

PHONE:

PHYSICIAN'S ADDRESS:

CITY ZIP CODE

## PARENT AUTHORIZATIONS

### INITIAL ALL THAT APPLY:

\_\_\_\_ My child may be included in water play activities.

\_\_\_\_ My child may be photographed for use in school publications.

\_\_\_\_ My family gives permission to print our family's name address, phone number and email address for your child's class list.

\_\_\_\_ I agree to read and follow all the policies outlined in the RJ's preschool academy enrollment packet.

\_\_\_\_ I understand that I must submit the state admission forms with my child's immunization records prior to the first day of school.

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**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)

# 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:

Blank space for listing 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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# 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)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ 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: \_\_\_\_\_ Date of Physical Exam: \_\_\_\_\_

Address: \_\_\_\_\_ Date This Form Completed: \_\_\_\_\_

Telephone: \_\_\_\_\_ Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

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**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.

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

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

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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## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### 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](http://www.meganslaw.ca.gov)*

### 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](http://www.meganslaw.ca.gov)*

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## TERMS OF ENROLLMENT

By signing this Enrollment Application, I (we) agree to the following: (1) student, parent and any guests in his/her party will abide by the terms of this Agreement at all times during the period of enrollment and will comply with all rules and regulations posted or otherwise communicated, (2) in case of illness or injury, The Salvation Army Kroc Center is authorized to secure emergency medical treatment at the student/parent/member expense, (3) The Salvation Army Kroc Center reserves the right to remove from the facility or terminate the enrollment of any student/parent/member who fails to comply with any posted rules and regulations or otherwise breaches the terms of this Agreement, in which case signer will not be entitled to a refund of dues, and (4) enrollment rights are not transferable.

### CONSENT TO TAKE AND PUBLISH PHOTOGRAPHS, VIDEO, AUDIO, AND MEDIA RECORDINGS

I hereby grant The Salvation Army, its agents and those by whom it is commissioned, unrestricted and unlimited license, right, permission, and consent to use and reuse, copyright, print, reproduce, publish, and republish, for any and all trade purposes or commercial or other advertising or public purposes, said media usage depicting me or a minor for whom I have legal responsibility. I warrant that I have not limited or restricted the use of my name or photograph to the use of any organization or person.

### LIABILITY WAIVER

I understand that use of the facilities and equipment at The Salvation Army Kroc Center may involve risk of bodily injury or property damage and I agree to assume any such risks. I understand that it is up to me to consult physicians and other professionals to make sure that myself and any minor for whom I have legal responsibility can safely participate in activities and events at The Salvation Army Kroc Center. I also understand and agree that by signing this Agreement, I am giving up my (or the minor for whom I sign) right to make any claim against The Salvation Army, its agents, employees and volunteers, including the right to sue them, for bodily injury or property damage or any other loss that I might suffer while using The Salvation Army Kroc Center facilities and services, except as limited by law.

### NOTICE

In order to promote a safe and secure environment, The Salvation Army Kroc Center has placed video cameras in various locations. As part of our commitment to the safety of children and vulnerable persons, The Salvation Army Kroc Center reserves the right to consult public sources to determine whether any member or guest of any member poses an unreasonable risk of harm to its patrons, staff, or visitors.

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME(S) OF CHILD YOU ARE LEGALLY RESPONSIBLE FOR \_\_\_\_\_

## PARENT CONTRACT

### I UNDERSTAND THE FOLLOWING TO BE THE TERMS IN WHICH MY CHILD IS ENROLLED

#### MY CHILD'S SCHEDULE IS

- |  |  |
|--|--|
| <input type="radio"/> MONDAY-FRIDAY FULL DAY POTTY TRAINED           | <input type="radio"/> MONDAY-FRIDAY FULL DAY NON POTTY TRAINED           |
| <input type="radio"/> MONDAY/WEDNESDAY/FRIDAY FULL DAY POTTY TRAINED | <input type="radio"/> MONDAY/WEDNESDAY/FRIDAY FULL DAY NON POTTY TRAINED |
| <input type="radio"/> TUESDAY/ THURSDAY FULL DAY POTTY TRAINED       | <input type="radio"/> TUESDAY/ THURSDAY FULL DAY NON POTTY TRAINED       |
| <input type="radio"/> MONDAY-FRIDAY HALF DAY POTTY TRAINED           | <input type="radio"/> MONDAY-FRIDAY HALF DAY NON POTTY TRAINED           |
| <input type="radio"/> MONDAY/WEDNESDAY/FRIDAY HALF DAY POTTY TRAINED | <input type="radio"/> MONDAY/WEDNESDAY/FRIDAY HALF DAY NON POTTY TRAINED |
| <input type="radio"/> TUESDAY/ THURSDAY HALF DAY POTTY TRAINED       | <input type="radio"/> TUESDAY/ THURSDAY HALF DAY NON POTTY TRAINED       |

- \*My fee is \_\_\_\_\_ per month for these hours and days
- \*My child will be at preschool only during contracted days. Any changes in this schedule will require the Director's approval. **PLEASE INITIAL** \_\_\_\_\_
- \*No sick children will be accepted into the program and all ill children will be sent home
- \*I will contact the preschool office at (619)269-1580 between the hours of 6:30-9:30 am to report my child's absence.
- \*I agree to submit a medical excuse if my child is absent for more than one week and I understand that the child will not be readmitted without the medical excuse.
- \*If my child is absent for more than one week without contacting the school, my child will be dropped from the program and another child will be enrolled in my child's place.
- \*I am responsible to complete a drop form if my child is dropping from the preschool. If I drop my child from the program without a two week notice given to the school office, or director, I will be charged for those two weeks.
- \*I agree to bring a minimum of one change of clothing, and diapers as needed for my child.
- \*I also understand my child may bring a special blanket or stuffed animal for nap- but no other toys should be brought to the preschool.
- \*I will also bring a pair of shoes for my child in case of emergency which will be left at the preschool.
- \*I agree to pay all fees in advance and to adhere to the financial policies.

1. Tuition: Your monthly fee is due on \_\_\_\_\_

2. Late Charges: Your children need to be picked up by 6:00pm. If a child is not picked up there will be a late fee charged \$1 per minute after 6:00. The late charge will be added on the next bill.

3. Additional charges for half day program: Half day program is from 8:15-12:15. If you drop off your child prior to 8:15 am or pick-up after 12:15, a \$5 late fee for every hour or portion thereof will be added to your next bill.

\*Delinquent accounts: Your account become delinquent if not paid on the first day of the month your child is scheduled to attend. Your account will be charged a fee of \$25 on the 11th of each month that tuition is not received. A twenty day grace period is allotted on all accounts, after which your child will no longer be enrolled in preschool.

\*Returned checks: A fee of \$75 will be charged for any checks returned due to insufficient funds.

\*No child will be released from the preschool to any adult unless that adult is on the permission form. Or a signed permission slip must accompany that person. I will also notify the school by phone to prepare my child for the change.

\*It is my responsibility to keep the preschool staff updated of any changes that may affect my child, i.e. changes in work, home number, address, physician, custody, or visitation.

\*I give my child permission to take adult supervised walks on the Kroc center campus.

\*I have no objection to my child being included in photographs, slides or movies which may be used for preschool marketing.

\*I have read this registration packet and in signing this contract, I agree to follow its contents or my child could be withdrawn from the preschool with no tuition reimbursement for the current month. A new contract will be signed annually.

PARENT'S SIGNATURE \_\_\_\_\_ CHILD'S NAME (PRINT) \_\_\_\_\_ DATE \_\_\_\_\_