

**FOURSQUARE CHRISTIAN PRESCHOOL
ENROLLMENT CHECKLIST**

Student's Name _____ Date _____

_____ Appointment with Director (Mandatory before starting school)

_____ Student & Family Information

_____ Travel and Activity Authorization / Picture Release

_____ Consent for Medical Treatment

_____ Notification of Parent's Rights

_____ Notification of Personal Rights

_____ Identification and Emergency Information

_____ Child's Preadmission Health History – Parents Report

_____ Physician's Report

_____ Immunization Information / Birth Certificate

_____ FACTS Management Tuition Worksheet

_____ FACTS Management Tuition Agreement (after the worksheet is turned in)

_____ Admission Agreement

For office use only:

Interview _____ Accepted by _____ Amount Paid _____ Check # _____

FOURSQUARE CHRISTIAN PRESCHOOL
Student & Family Information

Student's Name: _____

Address: _____ City _____ Zip _____

Phone: _____ Date of Birth: _____ City of Birth: _____

Nationality: _____ Age: _____ Grade applying for: _____

Name and address of last school attended: _____

FAMILY INFORMATION

Student lives with (*check all that apply*): Mother Father Step Parent Legal Guardian

Grandparent Other _____

Legal Father's Name: _____

Address: _____ City _____ Zip _____

Employer: _____ Position: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Legal Mother's Name: _____

Address: _____ City _____ Zip _____

Employer: _____ Position: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Marital Status: Married Widowed Divorced Separated Never Married Remarried

Stepfather's/mother's Name: _____

Legal custodial of student? Yes No How long related to student? _____

Employer: _____ Position: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Guardian's Name: _____

Address: _____ City _____ Zip _____

Employer: _____ Position: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Names of children living at home:	Age	Relation to student:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOURSQUARE CHRISTIAN PRESCHOOL
TRAVEL AND ACTIVITY AUTHORIZATION

I give permission for my child_____

to attend activities held at Foursquare Christian School and Preschool, ie: Sanctuary, Gym, Blacktop, Fireside Room and the School Playground.

Restriction(s) on such trips:_____

Signature_____Date_____

Field trip forms will be sent home at least one week in advance for field trips not held at our location.



PICTURE RELEASE

I hereby give my consent to let my child(ren) be photographed for/by the Preschool/ Daycare Center to be displayed in the classroom, used in newspaper or other media.

Signature_____Date_____

**FOURSQUARE CHRISTIAN PRESCHOOL
CONSENT FOR EMERGENCY MEDICAL TREATMENT
Child Care Centers Or Family Child Care Homes**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO THE
FOURSQUARE CHRISTIAN PRESCHOOL TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR
_____. THIS CARE MAY BE GIVEN UNDER WHATEVER
CHILD'S NAME
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

LIC 627 (5/01)(CONFIDENTIAL)

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS RIGHTS

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

1. Enter and inspect the family child care home 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: Community Care Licensing
 Licensing Office Address: 1330 Bayshore Way #103 Eureka, CA 95501
 Licensing Office Telephone #: 707-441-3939

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.

LIC 995 (8/02)

(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.

Foursquare Christian Preschool
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.

LIC 995 (802)

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is <http://cclid.ca.gov/docs/maps/state/htm>

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 Community Care licensing		
ADDRESS 1330 Bayshore Way #103		
CITY Eureka, CA	ZIP CODE 95531	TELEPHONE NUMBER 707-441-3939

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:

ACKNOWLEDGEMENT: 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) Foursquare Christian Preschool	(PRINT THE ADDRESS OF THE FACILITY) 144 Butte St. Crescent City, CA 95531
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(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)
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**IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**

To Be Completed by Parent of Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEHOME ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
FATHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE	()				
MOTHER'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 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 PERSONS WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT 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'S PREAMMISSION HEALTH HISTORY – PARENT'S REPORT

CHILD'S NAME	SEX	BIRTHDATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER 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:

<input type="checkbox"/> Chicken Pox	DATES	<input type="checkbox"/> Diabetes	DATES	<input type="checkbox"/> Poliomyelitis	DATES
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubella)	
<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?*
<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 CHILDS 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 SID 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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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)
FOURSQUARE CHRISTIAN PRESCHOOL. This Child Care Center/School provides a program which extends from 7:30 a. m. to 5:30 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 FO 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: _____
Other: _____

Other (include behavioral concerns): _____

Comments/Explanations: _____

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

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	1 ST	2 ND	3 RD	4 TH	5 TH
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/DT/d (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HEAMOPHISUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing to the right)

- 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.

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.

Physician: _____

Date of Physical Exam: _____

Address: _____

Date This Form Completed: _____

Telephone: _____

Signature: _____

- Physician Physician's Assistant Nurse Practitioner

Tuition Worksheet

The Foursquare Christian School and Preschool uses the FACTS Tuition Management Service to manage our tuition collection. This service is a simple, convenient way of collecting tuition that is confidential and secure. It also helps our school be more efficient and control costs so that future increases are kept at the lowest possible level. This enables us to focus on the quality of education your student receives.

Student's Name _____

Please read the following carefully and fill all that applies to your child.

PRESCHOOL: Ages 2-3

2, 3 or 5 Day per week program

8:00 am – 12:00 pm

Days of attendance per week	Annual Tuition	10 Monthly Payments (Sept. – June)	11 Monthly Payments (Aug. – June)	12 Monthly Payments (Aug. – July)
<input type="checkbox"/> 2 (Tue. & Thurs.)	\$150 a month X 9 ½ months + \$120 Reg. = \$1545.00	<input type="checkbox"/> 154.50	<input type="checkbox"/> 140.45	<input type="checkbox"/> 128.75
<input type="checkbox"/> 3 (Mon., Wed., Fri)	\$175 a month X 9 ½ months + \$120 Reg. = \$1782.50	<input type="checkbox"/> 178.25	<input type="checkbox"/> 162.05	<input type="checkbox"/> 148.54
<input type="checkbox"/> 5 (Mon. – Fri.)	\$250 a month X 9 ½ months + \$120 Reg. = \$2495.00	<input type="checkbox"/> 249.50	<input type="checkbox"/> 226.82	<input type="checkbox"/> 207.92

PRE-KINDERGARTEN: Ages 4-5

5 Day per week program

8:00 am – 12:00 pm

Days of attendance per week	Annual Tuition	10 Monthly Payments (Sept. – June)	11 Monthly Payments (Aug. – June)	12 Monthly Payments (Aug. – July)
<input type="checkbox"/> 5 (Mon. – Fri.)	\$250 a month X 9 ½ months + \$120 Reg. = \$2495.00	<input type="checkbox"/> 249.50	<input type="checkbox"/> 226.82	<input type="checkbox"/> 207.92

➡ Payment Options: (choose one)

_____ I would like to be **Invoiced**. I understand that my check will be due to FACTS Mgt. Co. by the 1st of each month.

_____ I would like my payment to be taken directly out of my bank account as an **Electronic Transfer**. I would like the payment to be taken out on the: 5th or 20th of each month

Peace of Mind POM: *In the event of the death of the Responsible Party or his/her legal spouse, FACTS will pay the remaining unpaid balance up to \$30,000 (except payments in arrears) on the agreement. Exceptions apply, for more information contact the school office. The nonrefundable fee for this benefit is \$12.00 per year.*

➡ _____ **Yes**, please enroll me in POM. _____ **No**, please to not enroll me in POM.

I have reviewed the above and indicated the School Schedule and Payment Options that I would like for the upcoming school year.

_____ Signature

_____ Date

FOURSQUARE CHRISTIAN PRESCHOOL
ADMISSION AGREEMENT

Date: _____

I (we) the parents of _____

Hereby verify that I (we) have read and discussed with the Director of Foursquare Christian Preschool the Preschool Manual and agree to the terms therein.

Mother's Signature _____

Father's Signature _____

Director's Signature _____