



FREE CHAPEL
PRESCHOOL

REGISTRATION PACKET
2019 - 2020

TUITION & FEES

Full Day (8:30am – 4:30pm)

Monday-Friday	5 days per week	\$1,150 (per month)
MWF	3 days per week	\$750 (per month)
T/TH	2 days per week	\$590 (per month)

Half Day (8:30am – 12:00pm)

Monday-Friday	5 days per week	\$840 (per month)
MWF	3 days per week	\$580 (per month)
T/TH	2 days per week	\$390 (per month)

AM Extended Care (7:00am – 8:30am)	\$100 (per month)
PM Extended Care (4:30pm – 6:00pm)	\$100 (per month)

Daily rate of \$10 per Extended Care Session may be added not to exceed \$200 per month.

The following fees and first month tuition will be due upon enrollment.

Non-refundable Registration Fee	\$200
Supply Fee (due every August)	\$100
Curriculum/Technology STEM Fee for Pre-K Class	\$57
Emergency Kit	\$15
Non Potty - Trained Fee	\$5(per day)

FREE CHAPEL PRESCHOOL SCHEDULE

7AM - 8:30AM	Early morning drop-offs for extended care participants. Individual classroom activities.
8:30AM	Pre-school drop off in classrooms – table top activities
9AM – 9:20AM	Chapel Time
9:20AM	Morning Circle Time – individual classrooms
9:40AM	Morning Snack Time
9:50AM – 11:30AM	Each class will have their own individual time with the following during this time period <ul style="list-style-type: none">• Learning centers• Crafts• Language development• Playground• Free play• Letter and number recognition/practice• Bathroom break
11:30AM	Lunch
12PM	Half Day Pick-Up Time
12PM	Quiet activities and learning centers
12:45PM	Naptime
2PM– 4:30PM	Afternoon crafts and activities
4:30PM	Afternoon Pick-up Time
4:30PM – 6PM	Extended care activities & Afternoon Snack

SNACK MENU FOR THE WEEK

(SAMPLE)

	AM SNACK 9:40AM	PM SNACK 4:45PM
MONDAY	string cheese & wheat thins	gogurt & 1/3 cup of cheerios
TUESDAY	½ cup of apple slices & 1 tbsp of peanut butter	½ cup of orange juice & cheezits
WEDNESDAY	gogurt & 1/3 cup of cheerios	string cheese & ½ cup of apple slices
THURSDAY	blueberry muffin & ½ cup of apple juice	graham crackers & peanut butter & apple slices ½ cup
FRIDAY	gogurt & 1/3 cup of cheerios	string cheese 1 1/2 oz & wheat thins

REGISTRATION CHECKLIST

- Enrollment Sheet
- Admissions Agreement
- Physicians Report
- Consent for Emergency Medical Treatment
- Parents Report on Health History
- Notification of Parents Rights
- Identification and Emergency Information
- Personal Rights
- Copy of Immunization Card
- Registration Fee
- Supply Fee
- STEAM Fee for Pre-K
- Emergency Kit Fee
- Picture for Family Wall

FREE CHAPEL PRESCHOOL ENROLLMENT PACKET

Student First Name _____ Middle _____ Last _____

Date of Birth _____ Allergies yes ___ no ___

List all allergies _____

Father Name _____ Cell # _____

Mother Name _____ Cell # _____

Names and Ages of Siblings _____

Parent Email Address _____

Home Address _____

Church Affiliation _____

Free Chapel Active Members Receive Discounted Tuition

Is this your child's first PS experience? ___yes ___no

Any concerns or fears we should be aware of _____

**Emergency Contact Person that is authorized to pick
up your child in the event you are un-available**

Name _____ Cell # _____

Name _____ Cell # _____

Program Selection

___ Monday through Friday ___ ___ MWF ___ T/TH

___ 8:30 – 4:30 or ___ 8:30 – 12:00

___ AM care 7:00 – 8:30 ___ PM care 4:30 – 6:00

Days extended care will be needed M ___ T ___ W ___ TH ___ F ___



FREE CHAPEL PRESCHOOL ADMISSION AGREEMENT

I am enrolling my child in Free Chapel Preschool. I understand that this a partnership in the development and education of my child. I understand and agree to the following:

- I will be notified of any concerns in my child's development.
- I will immediately be notified if there is any serious injury involving my child.
- I will be notified at the end of the day if my child has had a minor incident.
- I will immediately be notified if there is an emergency and my child is being transported to a safe and secure location. I will also be told where that secure location is so that I can retrieve my child.
- I will be charged an additional fee if I neglect to bring my child's lunch.
- I will be charged an additional fee if I am late to pick up my child for their scheduled session.
- In the event that I cannot pick up my child I will call and notify who is authorized to do so that day. I understand that individual will not be able to pick up my child without showing a valid id to the preschool staff.
- I understand that if my child is ill and contagious they are not to attend school and all symptoms must be gone for 24 hours prior to their return. I also understand that days my child is sick will not be refunded.
- I understand that Free Chapel Preschool is in full compliance with California Child Care Licensing Division Title 22 Regulations.
- I understand that the staff at FCPS are fully qualified and trained in CPR and First Aid Safety Measures.
- I understand that my child will not be disciplined in a harsh manner including voice tone or being touched in any inappropriate way.
- I understand that there are security cameras in every classroom assuring that nothing will ever occur that is not appropriate.
- I understand that tuition is due by the 1st of each month. If the 1st falls on a weekend, it is due the Friday prior. I also understand I will be charged if my payment is delinquent or if my check does not clear. I can pay for tuition with check, cash, or credit card. I will be given a tuition payment statement at the end of the school year.
- I understand that I am responsible for payment on days (including holidays) that the school is closed.

Name of Child: _____

Parent Name: _____

Parent Signature _____

Date: _____



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: _____
Address: _____
Telephone: _____

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

Physician Physician's Assistant Nurse Practitioner

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 area for listing medication allergies.

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

()

WORK PHONE

()

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

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

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