ENROLLMENT CHECKLIST

Welcome to ALC Preschool! The following checklist will help you manage the papers needed to start school. One form, LIC 701, requires a doctor's signature so please allow time for your doctor to return that to you. If you have any questions please contact us at Preschool@alcrpv.org or call us at **(310) 373-6083.**

_____ Registration Form

_____ LIC 613A: Personal Rights

_____ LIC 627: Consent for Medical Treatment

_____ LIC 700: Identification and Emergency Information Form

_____ LIC 701: Physician's Report

_____ LIC 702: Child's Preadmission Health History – Parent Report

_____ LIC 995: Child Care Center Notification of Parent's Rights

_____ LIC 995E: Caregiver Background Check

_____ Emergency Card (Fill out all 4 parts)

_____ Financial Agreement

_____ Admission Agreement

_____ Emergency Disaster Release

_____ Blog/Social Media/Website/Google Group Consent Form

_____ Chapel Sign-up Consent form

_____ Sunscreen Consent form

_____ Community Book Form (pick up at school or request via email)

_____ Allergy Update

_____ Anaphylaxis Emergency Care Plan (Optional - Only if Epi-Pen kept at school)

_____ 2 different 4x6 Family Photos

_____ Emergency Pack Ingredients: Ziploc Baggie with a change of clothing, including Underwear, a flashlight with batteries, and a letter from you to your child expressing that you will be with him/her as soon as you are able and that their teachers will take good care of them until you arrive.

_____ 1 ½ inch clear view 3-ring binder

_____ One package of 8 ½ x 11 sheet protectors

_____ Full Day Students: Crib Size sheet and small blanket. A small cuddly sleep toy Or small pillow (that fits inside a reusable grocery type bag).

Please be sure that you have turned in all items prior to your child's first day of school.

26231 Silver Spur Road, Rancho Palos Verdes, CA 90275 Tel (310) 373-6083 Fax (310) 378-7729

2023-2024 PRESCHOOL REGISTRATION

I would like to register my child for the following program starting_____

Age:_____ _____2 year program _____3 to 5 year old program

We offer care from 8:00–9:00 am for no charge and from 7:00-8:00 am for $6.75 per half hour.

_____Half Day 9am to 12:30pm_____Full Day 9am to 4pm_____Extended Day 7am to 6pm

Number of Days: _____Five_____Four _____Three _____ Two

Days of the Week: _____Mon _____Tues _____Wed _____Thurs _____Fri

_____

Child's Name (Please Print) Male/Female Birth Date

_____

Address City Zip Home Phone

_____

Parent #1 Name Parent #1 Cell/Work Number Parent #1 E-mail Address

_____

Parent #2 Name Parent #2 Cell/Work Number Parent #2 E-mail Address

_____

Place of Birth Does your child have preschool experience?

I UNDERSTAND THE REGISTRATION AND MATERIALS FEE ARE NON-REFUNDABLE AND THE SECURITY DEPOSIT WILL BE APPLIED TO YOUR CHILD'S LAST MONTH WITH US.

_____

Parent/Guardian Signature **Date**

For office use only:

Security deposit/ Registration/ Materials Fees Received $_____ check_____ cash _____

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

CCLD- El Segundo Child Care Regional Office

ADDRESS

300 N Continental Boulevard Suite 290A, MS 29-13

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
El Segundo	90245	424-301-3077

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)
Ascension Lutheran Preschool	26231 Silver Spur Rd. Rancho Palos Verdes, 9027[illegible]

(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

Ascension Lutheran Church Preschool
FACILITY NAME
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
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
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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)

Ascension Lutheran Church Preschool . 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

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.

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE 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
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

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?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

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: CCLD- El Segundo Child Care Regional Office

   Licensing Office Address: 300 N Continental Boulevard 290A, MS29-13 El Segundo CA90245

   Licensing Office Telephone #: 424-301-3077

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

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 or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, 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://ccld.ca.gov/contact.htm.**

EMERGENCY CONTACT INFORMATION

CHILD'S NAME	CHILD'S BIRTH DATE
MOTHER'S NAME	FATHER'S NAME
MOTHER'S CELL #	FATHER'S CELL #
MOTHER'S WORK #	FATHER'S WORK #
HOME ADDRESS	
CITY	HOME PHONE #

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF THREE PEOPLE WHO YOU AUTHORIZE TO PICK UP YOUR CHILD FROM SCHOOL IN CASE OF AN EMERGENCY:

#1 NAME	#1 PHONE #
#2 NAME	#2 PHONE #
#3 NAME	#3 PHONE #
CHILD'S DOCTOR'S NAME	DOCTOR'S PHONE #

EMERGENCY CONTACT INFORMATION

CHILD'S NAME	CHILD'S BIRTH DATE
MOTHER'S NAME	FATHER'S NAME
MOTHER'S CELL #	FATHER'S CELL #
MOTHER'S WORK #	FATHER'S WORK #
HOME ADDRESS	
CITY	HOME PHONE #

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF THREE PEOPLE WHO YOU AUTHORIZE TO PICK UP YOUR CHILD FROM SCHOOL IN CASE OF AN EMERGENCY:

#1 NAME	#1 PHONE #
#2 NAME	#2 PHONE #
#3 NAME	#3 PHONE #
CHILD'S DOCTOR'S NAME	DOCTOR'S PHONE #

EMERGENCY CONTACT INFORMATION

CHILD'S NAME	CHILD'S BIRTH DATE
MOTHER'S NAME	FATHER'S NAME
MOTHER'S CELL #	FATHER'S CELL #
MOTHER'S WORK #	FATHER'S WORK #
HOME ADDRESS	
CITY	HOME PHONE #

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF THREE PEOPLE WHO YOU AUTHORIZE TO PICK UP YOUR CHILD FROM SCHOOL IN CASE OF AN EMERGENCY:

#1 NAME	#1 PHONE #
#2 NAME	#2 PHONE #
#3 NAME	#3 PHONE #
CHILD'S DOCTOR'S NAME	DOCTOR'S PHONE #

EMERGENCY CONTACT INFORMATION

CHILD'S NAME	CHILD'S BIRTH DATE
MOTHER'S NAME	FATHER'S NAME
MOTHER'S CELL #	FATHER'S CELL #
MOTHER'S WORK #	FATHER'S WORK #
HOME ADDRESS	
CITY	HOME PHONE #

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF THREE PEOPLE WHO YOU AUTHORIZE TO PICK UP YOUR CHILD FROM SCHOOL IN CASE OF AN EMERGENCY:

#1 NAME	#1 PHONE #
#2 NAME	#2 PHONE #
#3 NAME	#3 PHONE #
CHILD'S DOCTOR'S NAME	DOCTOR'S PHONE #

_____day Tuition Financial Agreement

This document serves as an agreement of all of our financial requirements at Worlds of Wonder. Tuition for the 2023-2024 academic year is $_____ per month due upon enrollment and on the first of each month.

On the 5th day of the month, if tuition is not received, there will be a $50.00 late fee. An additional $25 fee will be added for each week of late payment thereafter because of the additional time and effort required in tracking the late tuition down and additional trips to the bank. If tuition is not received by the 21th of the month, your child will not be able to attend until tuition and additional fees are paid in full.

There is a nonrefundable one-time enrollment fee of $150 due at the time of enrollment. I am aware that there is a yearly materials fee of $200 due upon enrollment and in September each year after that.

One-month tuition deposit of $_____ is required when your child begins to attend our facility. It is used towards your final month's tuition when given 30 days' notice. I understand that if I chose to leave without a 30 day notice, this deposit is forfeited.

There will be a $35 charge for any returned checks due to non-sufficient funds to cover the bank fees.

I understand that there is no allowance for absences or holidays and there are no make-up days or refunds. I understand that tuition is due whether or not my child attends school that month.

I agree to notify the school one month in advance of withdrawal, should that be necessary. I understand that for withdrawal without notification, the school will not return the month tuition. Withdrawal mid-month will result in a prorated fee only when one month notice is provided.

My signature below signifies that I understand and agree to the statements above.

_____ _____

(Signature) (Date)

For Office Use Only

Enrollment Check # _____ amount $_____date_____ includes current month, deposit, enrollment fee, and materials fee.

Parent Contract 2023-2024 School Year
Admission Agreement

- I understand the **Tuition Fees** are payable on the first of each month and that there will be additional charges for late tuition. I understand that there is no refund for any of the fees paid to our center. I have completed a financial agreement form.
- I understand the **Arrival and Departure Procedures** and will legibly sign my child in and out using my full name on the sign in/out sheets or iPad.
- If my child attends full day, I understand that he or she may spontaneously stay longer to rest and play as part of our **"Stay and Play Program"** at the rate of **$7.00 per half hour** by calling to let us know.
- I understand that the school closes at 6:00 pm and I will have to pay additional fees of one dollar per minute if I am late in picking my child up.
- I understand that **Communication** is important and agree with World of Wonder Early Learning Center's communication policies.
- I understand **Hours, Days, and Breaks** for the school year and have a copy of the school calendar.
- I know that my child will be expected to rest for a period of time at school when attending full-time.
- I will bring **Healthy Lunches** each day. No nuts and sugary items are allowed during school hours.
- My child will wear appropriate **Clothing.**
- I will abide by the **Health and Safety** policies here and will keep my child home if he or she is sick or contagious. I will be contacted immediately in the case of a **Medical or Dental Emergency.**
- I understand the **Emergency Plan and Drill Procedures** and what is needed for my child's earthquake kit. I also understand about the school's **Safety Drill policy**.
- I understand the importance of **Parent Involvement** and will become an active member of this school. I will participate in fundraising by donate items to our auction, contribute time for the success of the event and purchasing event and raffle tickets in the amounts determined by The Fundraising Committee, and will join one of the **Parent Committees**.
- I understand the school's policy regarding **Behavior Problems** and will be open to creating a plan with the teachers here to minimize undesired behaviors.
- I understand that my child may lose the ability to attend school here if I do not comply with the policies and procedures listed in this handbook and our operation plan or for any issues that cannot be worked out with the school's director.
- I am in agreement that **Photos and Videos** may be taken of my child while in school which may be used for documentation, education, and training purposes, yet I will not post any personal photos or videos anywhere online. All artwork created by the children is property of ALC Preschool and may be used to promote our program, in educational workshops, and/ or on our website or social media pages.
- I authorize that my child may attend walking field trips throughout the neighborhood (without crossing any major streets) to enhance learning experiences.

I have read all of the information in this handbook, which includes the policies and procedures of our Early Learning Center. I agree with the above statements and I will make sure to follow up if I have any questions:

_____	_____	_____
Parent's Name	Parent's Signature	Date

Ascension Lutheran Preschool
26231 Silver Spur Road
Rancho Palos Verdes, CA 90275
310-373-6083

Class Room_____

EMERGENCY DISASTER RELEASE

Child's Name_____ Date of Birth_____

Mother's Name_____ Father's name_____

Address_____

Home Phone #_____ Cell Phone #_____

In the event of a disaster or in case of emergency my child may be released to the persons authorized on this release form. As it may be impossible for parents/guardians to reach the school, please include three additional local contacts including carpool drivers, nannies, or housekeepers. Please remember- your child will be released only to the people on this form.

LOCAL EMERGENCY CONTACTS:

1. _____
   Name Address Home Phone Work Phone
2. _____
   Name Address Home Phone Work Phone
3. _____
   Name Address Home Phone Work Phone
4. _____
   Name Address Home Phone Work Phone
5. _____
   Name Address Home Phone Work Phone

OUT OF STATE CONTACT:

1. _____
   Name Address Home Phone Work Phone

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent/parents or legal guardian of_____a minor, do hereby authorize and consent to any x-ray examination, medical or surgical diagnosis, and treatment. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

Signature of Parent/Guardian:_____ Date:_____

Released to:_____ Date & Time:_____ Destination:_____

Ascension Lutheran Church (ALC) Preschool Documentation/Photograph Blog and Google Group Consent Form

I HEREBY GRANT PERMISSION, AND THE RIGHT, TO PHOTOGRAPH AND RECORD MY CHILD IN ANY MEDIA (INCLUDING, WITHOUT LIMITATION, STILL PHOTOGRAPHY, VIDEOTAPE AND AUDIO RECORDINGS) AND TO USE, PUBLISH AND DISTRIBUTE SUCH PHOTOGRAPHS AND RECORDINGS IN ANY MEDIA (INCLUDING SCHOOL WEBSITE, SOCIAL MEDIA PAGES) IN CONNECTION WITH THE SCHOOL, ITS PROGRAMS AND ACTIVITIES, AND THE MARKETING AND PROMOTION THEREOF.

I GRANT, ASSIGN AND CONVEY FULL OWNERSHIP, COPYRIGHT AND ANY OTHER RIGHTS IN ANY AND ALL PHOTOGRAPHS PRODUCED IN THIS SCHOOL TO ALC PRESCHOOL, ALONG WITH THE RIGHT TO REPRODUCE ANY OF THE PHOTOGRAPHS (BY ANY MEANS OR METHOD, AND IN ANY MEDIUM, NOW KNOWN OR CREATED IN THE FUTURE).

I AGREE THAT I WILL NOT SHARE MY PERSONAL LOG IN INFORMATION THAT MIGHT ALLOW OTHER PEOPLE TO ACCESS OR VIEW THE SCHOOL'S PHOTOGRAPHS ONLINE. I ALSO AGREE THAT I WILL NOT COPY, DOWNLOAD OR PRINT THE IMAGES FOR PERSONAL USE OR SHARING.

I HEREBY RELEASE ANY LEGAL CLAIMS OR DISPUTES, NOW OR IN THE FUTURE, AGAINST EITHER THE PHOTOGRAPHER, TEACHERS OR SCHOOL IN REGARDS TO THE USE OF ANY DERIVATIVE WORKS CREATED THEREFROM, AND UNDERSTAND FULLY THAT THE PHOTOGRAPHER/TEACHER/SCHOOL IS UNDER NO LEGAL OBLIGATION TO COMPENSATE ME FOR THE USE OF ANY PHOTOGRAPH(S).

I thoroughly read and understand this contract. By signing below, I agree to all the terms as set Forth above.

Signature X_____(date)_____

Signature X_____(date)_____

IMPORTANT! A signature is required of either parents or legal guardians of your child

Parent/Guardian X_____(date)_____

Chapel sign-up

Child's name _____ Class 3-5 or 2yr olds _____

☐ My child can attend Chapel

☐ My child cannot attend Chapel

Chapel is on Monday mornings and consists of a shortened bible story and chapel songs with Pastor Scott from Ascension Lutheran Church. The teachers stay with the children at all times. Chapel takes place in the Sanctuary or the church patio. Parents are welcomed to join the 2nd and 4th Monday of each month.

Parent signature x_____(date)_____

Notes:

_____

_____

_____

Sunscreen Application permission form

ALC Preschool Worlds of Wonder staff members have my permission to apply Sunscreen to my child,_____ while in their care.

x_____

Parent Signature Date

Notes:_____

_____

_____

_____

Community Book Information

This information will be typed into a booklet and presented to all of the families in our center to help build community within our school. It will help us get to know one another better. Please complete the portions of the statements below that apply to your family and return with your enrollment paperwork. When you see his/her or she/he etc..., please circle the appropriate word. If your child has a nanny, please complete the information for other guardian and specify "nanny". We do not want to leave out someone who is that special to your child.

I would like you to meet (child's name)_____'s family. His/Her mother/father/other guardian's name is _____ and he/she was born in_____ and grew up in _____. She/He works as a _____ and loves to _____. His/Her mother/father/other guardian's name is _____ and he/she was born in_____ and grew up in _____. She/He works as a _____ and loves to _____. His/Her mother/father/other's name is _____ and he/she was born in_____ and grew up in _____. She/He works as a _____ and loves to _____. His/her brother/sister's name is _____, a he/she is _____ years old. He/she loves to _____. His/her other brother/sister's name is _____, a he/she is _____ years old. He/she loves to _____. We have a pet (kind of animal) _____ named _____. As a family we love to _____ on the weekends. Our favorite place to visit is _____ and our favorite park is _____. What our family brings to this community is _____.

ALLERGY UPDATE

Child's Name _____ Date _____

My child is allergic to the following: (food and medications)

_____

_____

_____

_____

_____

_____

Special Instructions:

_____

_____

_____

_____

_____

_____

Epi-pen to be kept at school?

_____ Yes (Complete Allergy Action Plan Form with your doctor's signature)
_____ No

Parent signature _____ Date _____

Doctor's Name _____ Phone # _____

Ascension Lutheran Church & Preschool
26231 Silver Spur Road
Rancho Palos Verdes, CA 90275
310-373-6083
preschool@alcrpv.org

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

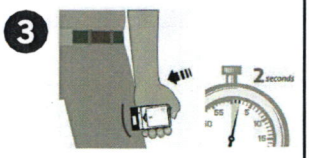
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

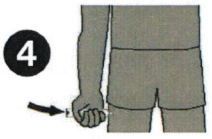
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



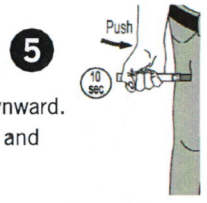
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

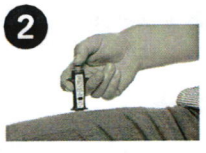


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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