PAPERWORK DUE DATE: _____

parent packet

All paperwork must be completed and returned to the school **PRIOR** to your child's first day. No exceptions.

	A COPY OF YOUR CHILD'S IMMUNIZATION RECORD
	PHYSICIAN'S REPORT (LIC 701) ***COMPLETED BY YOUR CHILD'S DOCTOR***
	AUTHORIZATION TO ADMINISTER SUNSCREEN AND/OR TOPICAL OINTMENT AT SCHOOL ***NOTE SIGNED BY YOUR CHILD'S DOCTOR***
	PERMISSION TO RE-APPLY SUNSCREEN FORM AND/OR TOPICAL OINTMENT CREAM
	IDENTIFICATION AND EMERGENCY INFORMATION (LIC 700)
	CHILD'S PREADMISSION HEALTH HISTORY REPORT (LIC 702)
	CONSENT FOR EMERGENCY MEDICAL TREATMENT (LIC 627)
	PERSONAL RIGHTS (LIC 613A)
	NOTIFICATION OF PARENTS' RIGHTS (LIC 995)
	PARENT INTEREST SURVEY
	MEDIA/PHOTOGRAPHY CONSENT & RELEASE FORM
	ENRICHMENT CLASS PARTICIPATION
	CONSENT FOR EMERGENCY TREATMENT
	TUITION EXPRESS REGISTRATION FORMS
	PARENT HANDBOOK RECEIPT

PLEASE CONTACT US WITH ANY QUESTIONS

OFFICE HOURS: M-F 8:30am-2:30pm
Phone: (858)481-7933 Fax: (858)436-1375
E-Mail: cvps@gracepointsd.com

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)

CARMEL VALLEY PRESCHOOL . This Child Care Center/School provides a program which extends from 07 : 30a
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:00p a.m./p.m. , 5 (M-F) 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

Sun Protection Authorization Form for Carmel Valley Preschool

To Whom It May Concern:

_____ [CHILD'S NAME]

should be allowed to practice proper sun protection during school hours. This includes:

☐ Bringing sunscreen to school, applying when going outdoors and reapplying as needed for times when child will have exposure to the sun.

☐ Wearing a wide-brimmed hat when outdoors [parent provided]

☐ Wearing sunglasses when outdoors for medical condition [parent provided]

Signed,

_____ _____

[PHYSICIAN NAME] [PHYSICIAN SIGNATURE]

Practice name/phone/address [Stamp ok]: _____

_____

_____

_____ _____

[PARENT NAME] [PARENT SIGNATURE]

This form approved by:

www.SkinCancer.org

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

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

DATE OF ADMISSION	DATE LEFT

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

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

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

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

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

	DATES		DATES		DATES
☐ 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'S 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'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

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

Carmel Valley 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

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

Carmel Valley 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

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

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
7575 Metropolitan Drive Suite 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Diego	92108	(619)767-2200

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)
Carmel Valley Preschool	13340 Hayford Way San Diego,CA 92130

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(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: Community Care Licensing Division

   Licensing Office Address: 7575 Metropolitan Drive Suite 110 San Diego, CA 92106

   Licensing Office Telephone #: (619)767-2200

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.

Carmel Valley 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.

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

CARMEL VALLEY PRESCHOOL

13340 Hayford Way San Diego, CA 92130
www.cvpreschool.org (858)481-7933

CONSENT FOR EMERGENCY TREATMENT

As the parent or authorized representative of _____, I hereby give consent to Carmel Valley Preschool to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.), Osteopath (D.O.S.), or Dentist (DDS). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above.

CARMEL VALLEY PRESCHOOL IS NOT RESPONSIBLE FOR PAYMENT OR PHYSICIAN'S FEES OR EXPENSES. I HEREBY RELEASE CARMEL VALLEY PRESCHOOL, ITS STAFF AND VOLUNTEERS OF THE LIABILITY FOR INJURY OR DAMAGE AND ASSUME ALL RISKS STEMMING FROM MY CHILD'S PARTICIPATION IN CARMEL VALLEY PRESCHOOL AND SPECIAL EVENTS.

MY CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____

Please list any FOOD or ENVIRONMENTAL allergies below, as well as the reaction caused and any medications required if child is exposed to allergen. If emergency medication (such as an epi-pen) is needed, you will be required to provide the medication and medical documentation to the school which will then be stored appropriately on campus.

	ALLERGY	**REACTION** (hives, anaphylaxis, etc.)	**MEDICATION**
1.			
2.			
3.			
4.			

Current Insurance Provider & Member Number: _____

Please list any medical condition(s) that hospital or emergency personnel should be made aware of:

_____

_____

Home Address: _____

Home Phone: (____)_____-_____ Work/Cell Phone: (____)_____-_____

Parent Signature: _____ Date:_____

CARMEL VALLEY PRESCHOOL

13340 Hayford Way San Diego, CA 92130
www.cvpreschool.org (858)481-7933

PARENT INTEREST SURVEY

Child's Name: _____

ALL ABOUT DAD

Dad's Name:_____

Vocation:_____

Hobbies: _____

_____

ALL ABOUT MOM

Mom's Name:_____

Vocation:_____

Hobbies: _____

_____

❑ I do not wish to volunteer in my child's classroom
❑ I am interested in volunteering in my child's classroom

POTENTIAL VOLUNTEER ACTIVITIES:

❑SERVING AS A ROOM PARENT
❑HELPING CHILDREN COOK
❑ GUIDING ART ACTIVITIES
❑ ASSISTING WITH MUSIC
❑ READING BOOKS TO CHILDREN
❑ DRIVING OR ACTING AS CHAPERONE ON FIELD TRIPS
❑ ASSISTING WITH LEARNING CENTERS
❑ SHARING HOBBIES OR COLLECTIONS
❑ TALKING ABOUT YOUR VOCATION
❑ HELPING PLANT A GARDEN
❑ HELPING WITH HOLIDAY CELEBRATIONS

❑CORPORATE SPONSORSHIP FOR LARGE PURCHASES
(THANKSGIVING TURKEYS, PLAYGROUND EQUIPMENT, ETC.)
❑ HELP WITH SPECIAL EVENTS
(THANKSGIVING FEAST, CHRISTMAS PROGRAM, EASTER, GRADUATION, ETC.)
❑ DONATING CREATIVE PLAY ITEMS
(CLOTHES, HATS, POTS, ETC.)
❑ OTHER _____

YOUR CHILD WILL BE DELIGHTED TO SEE YOU PARTICIPATING!

CARMEL VALLEY PRESCHOOL
13340 Hayford Way San Diego, CA 92130
www.cvpreschool.org (858)481-7933

MEDIA/PHOTOGRAPHY CONSENT & RELEASE FORM

We would appreciate it if parents completed this consent form in order to allow their children to be photographed during special events or normal day to day activities organized at Carmel Valley Preschool. In order for a child to have their photograph taken, they must have a consent form on file at Carmel Valley Preschool. If you do not want to have your child photographed, please do not hesitate to indicate this in the section below. As well, if you do object, please ensure that your child is aware of this.

As the parent of a child at Carmel Valley Preschool, I agree to the following:

- I understand that my child whose name is listed below may be photographed at Carmel Valley Preschool during normal hours, field trips, and/or activities.

- I understand that these photographs may be used in school newsletters or on the Carmel Valley Preschool website.

- I understand that my child's name will never be posted and I can revoke my consent at any time by contacting the office and signing a new form.

(Please print your child's full name):

_____

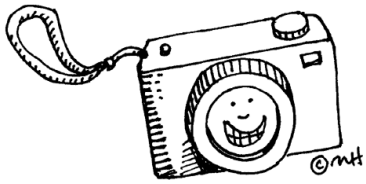
❑ Yes, I confirm that I have read and understood the above, and agree to have my child's photos taken and/or posted on the Carmel Valley Preschool website or newsletters.

❑ No, I do not wish to have my child photographed.

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____

Date: _____



CARMEL VALLEY PRESCHOOL
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www.cvpreschool.org (858)481-7933

PERMISSION TO APPLY SUNSCREEN AND/OR TOPICAL OINTMENT OR CREAM

I give my permission for personnel at Carmel Valley Preschool to apply sunscreen product of SPF-15 or higher to my child, as specified as below, when he or she will be playing outside, especially during the months of March through October and between the daily time of 10:00am and 4:00pm. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms and legs.

I have checked all applicable information regarding the type and use of sunscreen for my child:

☐I have provided the following brand/type of sunscreen for use on my child:

_____

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

_____

I give my permission for personnel at Carmel Valley Preschool to apply topical ointment or cream to my child.

☐I have provided the following brand/type of topical ointment for use on my child:

_____

**we cannot apply any OTC or RX creams or ointments to rashes or sores without written consent from a doctor as well as a physician statement confirming the rash/sores are NOT contagious.*

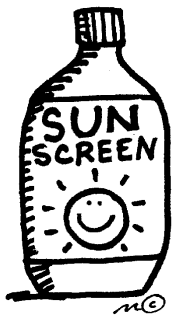
diaper rash creams will only be applied to children still in diapers unless there is a physician's order and appropriate completed paperwork.

Sunscreen and/or topical ointment or cream cannot be left in reach of children. Please label all items with your child's name and leave with their teacher. Licensing requires a physician's note to apply sunscreen and any topical ointment or cream.

Parent/ Guardian full name (print): _____

Parent/Guardian signature: _____

Date: _____



CARMEL VALLEY PRESCHOOL
13340 Hayford Way San Diego, CA 92130
www.cvpreschool.org (858)481-7933

ENRICHMENT CLASS PARTICIPATION

In order for your child to participate in any of our Enrichment Classes (any class provided by an outside company.) This authorization form will be completed and kept on file in the preschool office. We will keep it on file for future classes. If you ever want this to be removed from your child's file you must inform the office staff.

The enrichment teachers have fingerprints and education units on file. California state approved ratios are maintained for each enrichment class. If you have any questions about the classes, sizes or qualifications, please see us in the office. Thank you.

CONSENT FOR ENRICHMENT TEACHER PICK-UP

AS PARENT/LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO THE ENRICHMENT TEACHERS AT CARMEL VALLEY PRESCHOOL TO PICK UP MY CHILD,_____ FROM CLASS TO ATTEND ENRICHMENT PROGRAMS.

DECLINE PARTICIPATION IN ENRICHMENT CLASS

☐I DECLINE PARTICIPATION FOR MY CHILD, _____ TO ATTEND ENRICHMENT PROGRAMS HELD AT CARMEL VALLEY PRESCHOOL.

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____

Date: _____

CHILD'S NAME: _____

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) **CARMEL VALLEY PRESCHOOL** **to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ *(initial)* Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

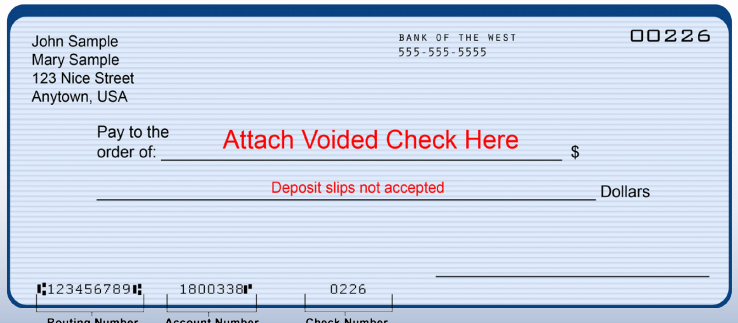
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

Parent Handbook Receipt

I have received a copy of the CVPS Parent Handbook. I am responsible for reading the rules, policies and requirements in the handbook and I agree and will comply with all the policies as stated. I also agree and understand that I am responsible for keeping myself updated and informed regarding CVPS policies and understand that I will be responsible for complying with any changes made. I understand that failure to follow these policies may lead to termination of childcare services. Each year I will be given a new handbook with any revisions and required to sign a new receipt for that handbook.

Initial: _____ I have read page 5: "Sign in & sign out" policy

Initial: _____ I have read page 7: "Late Pick-Up Charges"

Initial: _____ I have read pages 8 & 9 in their entirety

Initial: _____ I have read pages 14 & 15: "Discipline Policy"

Child's name: _____
Parent/Guardian printed name: _____
Parent/Guardian signature: _____
Date: _____