



# NEW ENROLLMENT REGISTRATION PACKET

All registration paperwork must be completed per child (not per family). *No registration forms or waitlist forms* will be accepted without completed paperwork. **NO EXCEPTIONS.** Any delay in paperwork will result in delayed start date.

	<b>IDENTIFICATION AND EMERGENCY INFORMATION (LIC 700)</b>
	<b>CHILD'S PREADMISSION HEALTH HISTORY REPORT (LIC 702)</b>
	<b>CONSENT FOR EMERGENCY MEDICAL TREATMENT (LIC 627)</b>
	<b>PERSONAL RIGHTS (LIC 613A)</b>
	<b>NOTIFICATION OF PARENTS' RIGHTS (LIC 995)</b>
	<b>CONSENT FOR EMERGENCY TREATMENT (CVPS FORM)</b>
	<b>PARENT INTEREST SURVEY</b>
	<b>MEDIA/PHOTOGRAPHY CONSENT &amp; RELEASE FORM</b>
	<b>ENRICHMENT CLASS PARTICIPATION</b> A VARIETY OF ENRICHMENT CLASSES WILL BE OFFERED DAILY ON OUR CAMPUS. ALL PAYMENTS AND SCHEDULED CLASSES ARE COORDINATED DIRECTLY WITH OUR VENDORS.
	<b>PERMISSION TO RE-APPLY SUNSCREEN FORM AND/OR TOPICAL OINTMENT CREAM (CVPS FORM)</b> ALL STUDENTS ENROLLED IN FULL DAY OR EXTENDED DAY SCHEDULES, WILL HAVE SUNSCREEN RE-APPLIED FOR THE AFTERNOON HOURS.
	<b>GPC LIABILITY WAIVER</b>
	<b>PARENT HANDBOOK RECEIPT</b> PLEASE READ OUR HANDBOOK AND SIGN
	<b>PHYSICIAN'S REPORT (LIC 701)</b> <b>THIS FORM WILL NEED TO BE SUBMITTED PRIOR TO YOUR CHILD'S FIRST DAY OF SCHOOL</b> <b>*MUST BE SIGNED &amp; STAMPED BY YOUR CHILD'S DOCTOR</b>
	<b>AUTHORIZATION TO ADMINISTER SUNSCREEN AND/OR TOPICAL OINTMENT AT SCHOOL (SKIN CANCER FOUNDATION FORM)</b> FOR HALF DAY SCHEDULE STUDENTS WILL NEED THIS FORM TO RE-APPLY SUNSCREEN/OINTMENTS AS NEEDED. FULL DAY OR EXTENDED DAY SCHEDULES, WILL HAVE SUNSCREEN RE-APPLIED FOR THE AFTERNOON HOURS. <b>THIS FORM WILL NEED TO BE SUBMITTED PRIOR TO YOUR CHILD'S FIRST DAY OF SCHOOL</b> <b>*MUST BE SIGNED &amp; STAMPED BY YOUR CHILD'S DOCTOR</b>
	<b>A COPY OF YOUR CHILD'S IMMUNIZATION RECORD</b> <b>THIS WILL NEED TO BE SUBMITTED PRIOR TO YOUR CHILD'S FIRST DAY OF SCHOOL</b> <b>*MUST BE SIGNED &amp; STAMPED BY YOUR CHILD'S DOCTOR</b>
	<b>TUITION EXPRESS FORM</b> TO MAKE PAYMENTS ONLINE OR SIGN UP FOR AUTOPAYMENTS

PLEASE CONTACT US WITH ANY QUESTIONS  
PHONE: (858) 481-7933 FAX: (858) 436-1375 E-MAIL: [CVPS@GRACEPOINTSD.COM](mailto:CVPS@GRACEPOINTSD.COM)

# 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					BUSINESS TELEPHONE
LAST					(    )
MIDDLE					
FIRST					
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE
LAST					(    )
MIDDLE					
FIRST					
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PERSON RESPONSIBLE FOR CHILD					BUSINESS TELEPHONE
LAST NAME					(    )
MIDDLE					
FIRST					
					HOME 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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**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?
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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*
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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

# 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

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

( )

## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Community Care Licensing

Licensing Office Address: 7575 Metropolitan Drive Suite 110

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

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

\_\_\_\_\_  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.**

*For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

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# 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)



# 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: \_\_\_\_\_

## **CORONAVIRUS DECLARATION & RELEASE<sup>1</sup>**

### **(“CDR”)**

The purpose of this Coronavirus Declaration & Release (“CDR”) is to inform the members of Grace Point Church (“Church”) of the risks associated with Coronavirus (“COVID-19”), a worldwide pandemic which can be a risk to the health and wellbeing of attendees. Depending on numerous factors, such as a compromised immune system, COVID-19 can be life threatening with a mortality rate that may be greater than the common flu. By signing this CDR and participating in this service, you acknowledge that the Church has provided you with notice of the risks associated with COVID-19 as well as the potential for contracting the virus despite best efforts to abide by the below recommended guidelines.

### **Declaration**

By signing this CDR you represent and warrant that you are voluntarily attending the Church, that you agree to take any and all necessary precautions including but not limited to the following:

- Follow all applicable Federal, State, or local laws and guidelines related to COVID-19 that may be amended from time to time;
- Take any and all reasonable precautions to protect yourself and others such as washing your hands with soap and water, applying hand sanitizer, or wearing a protective face mask to the extent recommended by health officials or required by law; and
- Maintain social distancing by maintaining a minimum of six (6) feet between yourself and other members who do not reside in your residence while on the Church premises.

In addition to the above, you are representing and warranting that, to the best of your current knowledge, you do not have COVID-19 and are not experiencing symptoms including but not limited to a fever, respiratory complications, shortness of breath, or difficulty breathing. Moreover, by signing this CDR, you represent and warrant that, to the best of your knowledge, you have not been in contact with anyone who was infected by COVID-19 within the last fourteen (14) days. Notwithstanding the above, you also acknowledge that individuals with COVID-19 can be asymptomatic and unable to self-diagnose or otherwise disclose a potential for infecting others.

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<sup>1</sup> DISCLAIMER: TYLER & BURSCH PROVIDES THIS GENERAL RELEASE OF LIABILITY FOR CHURCHES AND SIMILAR ORGANIZATIONS IN THE STATE OF CALIFORNIA AS A GUIDE TO FACILITATE RE-OPENING ONCE PERMITTED BY CALIFORNIA LAW. THIS DISCLAIMER IS NOT IN ANY WAY INTENDED TO OFFER SPECIFIC LEGAL ADVICE OUTSIDE CALIFORNIA OR TO ANY PARTICULAR INDIVIDUAL. IF YOU HAVE ANY QUESTIONS REGARDING RE-OPENING, YOU SHOULD CONTACT AN ATTORNEY AS THIS WAIVER SHOULD NOT BE USED AS INDIVIDUALIZED LEGAL ADVICE.



## Release of liability

By signing this CDR, you represent and warrant that you understand the risks and ramifications associated with participating in the service and agree to assume any and all risks of bodily injury or death, whether said risks are known or unknown at this time. In consideration for the Church permitting attendance and providing a worship experience for you, you hereby agree to forever release and discharge the Church, its subsidiaries, affiliates, agents, employees, officers, directors, owners, heirs, successors, assignees, and related companies from any and all claims, demands, debts, liabilities, obligations, costs, expenses, actions, or causes of action of every kind, nature, and description whatsoever including but not limited to wrongful death or negligence, whether known or unknown at this time, which you may have against the individuals set forth above as a result of attending or otherwise participating in the services provided by the Church.

**In the event that you fail to abide by the safety precautions established above, the Church reserves the right to immediately remove you from the premises for the safety of staff and others. If you have any questions, the Church encourages you to seek an attorney to review this CDR. By signing below, you agree, represent, and warrant that you have read the contents of this CDR, that you are understand its contents, and agree to comply with the safety precautions set forth herein.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Name of Minor

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Parent or Legal Guardian's Signature

Date: \_\_\_\_\_



# CARMEL VALLEY PRESCHOOL

13340 Hayford Way San Diego, CA 92130

[www.cvpreschool.org](http://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
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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: \_\_\_\_\_



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## 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.*

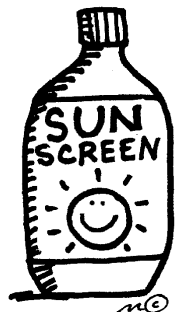
*diaper rash creams will only be applied to children still in diapers unless there is a physician's order and appropriate completed paperwork.*

*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: \_\_\_\_\_





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## 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!**



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## 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: \_\_\_\_\_



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## 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):**

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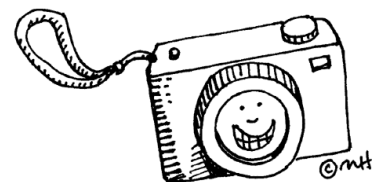
**Yes, I confirm that I have read and understood the above, and agree to have my child's photos taken and/or posted on the Carmel Valley Preschool website or newsletters.**

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

Parent/Guardian full name (print): \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_



# 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: \_\_\_\_\_

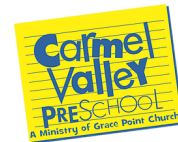
Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

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

Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner



# 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](http://www.SkinCancer.org)



# 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. 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.

**We accept  
VISA and MASTERCARD**

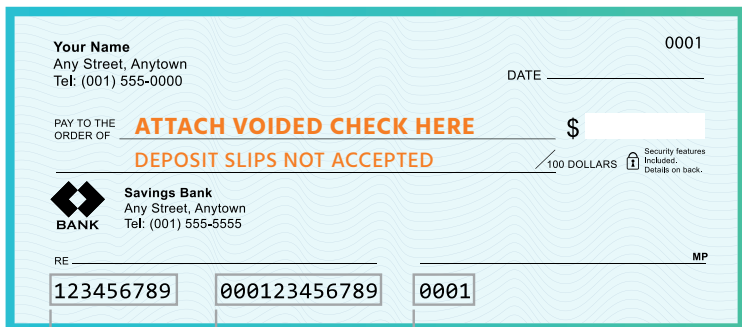
### COMPLETE ONE SECTION ONLY

#### SECTION A (Credit Card) 4% processing fee

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)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING  
NUMBER

ACCOUNT  
NUMBER

CHECK  
NUMBER

#### FOR OFFICIAL USE ONLY

_____
<b>Date Received</b>
_____
<b>Employee Signature</b>

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