

GREAT BEGINNINGS
PRESCHOOL/KINDERGARTEN

New Life Christian School

LIC # 125406576

1355 Ross Hill Road, Fortuna (Office)

609 Summer Street, Fortuna (Preschool Site)

P.O. Box 404, Fortuna

(707)725-9136

ADMISSIONS APPLICATION – Preschool/Kindergarten

I/We agree to have Great Beginnings Preschool/New Life Christian School care for my child _____ for _____ days per week, Morning Program _____ OR Afternoon Program _____.

I understand that the monthly payment will be \$ _____ for ten (10) consecutive months. A registration fee of \$75.00 (nonrefundable) and a book fee of \$125.00 are due with this application. A fee of \$30.00 will be charged to your account for returned checks as well as a late fee of \$10 if monthly payment isn't made by the 10th of the month.

I agree not to send my child to school when I suspect he/she may be ill. See Parent/Program information for health policies. We also require a nutritional snack to be brought daily.

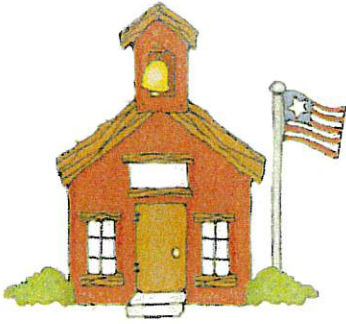
I have received the Parent/Program Information packet for Great Beginnings Preschool.

I have submitted the following enrollment papers. I agree to notify the school in writing if any of the information on these forms should need to be changed.

- _____ Application Information
- _____ Medical Treatment Consent Form (Lic 627)
- _____ Copy of current Immunizations Report from Physician
- _____ Physicians Report, Lic 701
- _____ Identification and Emergency Information Form (Lic 700)
- _____ Traveling Permission Form
- _____ Parent's Personal Right (Lic 995, Lic 613)
- _____ Copy of Original Immunization records
- _____ Copy of Birth Certificate
- _____ Photo Release Form

Parent's Signature _____ Date _____

Director's Signature _____ Date _____



Great Beginnings Preschool

609 Summer Street
P.O. Box 404
Fortuna, Calif. 95540

Rules for the release of children: For your child's protection, your child will be released only to his/her parents or names of people who have been authorized on the enrollment forms. Requests to have someone else pick up your child must be in writing. Please let us know in writing if custody of your child changes, or if there are problems concerning custody. Please give us a copy of any restraining orders concerning your child and his or her guardianship.

Health Policies: State Licensing Law requires an immunization record for your child to be on file with the facility prior to your child entering our program. The required form is included in the enrollment papers. A physician's report for health evaluation is also included in your enrollment packet and must be signed by a physician. We do not administer medications. If a child has a prescription the parent will need to administer it.

Your child should remain at home if he/she had any of the following:

- Diarrhea
- Vomiting (especially if accompanied by other symptoms)
- Fever (100' or above within the last 24 hours)
 If you child has a normal temperature different than 98.6, please let us know.
- Hepatitis
- Measles or Rubella
- Chicken Pox
- Mumps
- Pinkeye
- Too ill to participate actively in program

Please notify the school within 24 hours of a diagnosis of a serious illness in your family. You will be notified if your child has been exposed to a contagious illness or becomes ill at school.

Snacks: Snacks can be brought from home. We ask that you include two foods from the four major foods groups daily. Snacks are available daily for \$2.00. Great Beginnings is a PEANUT/NUT FREE Campus.

Personal Belongings: Please label your child's belongings (lunch box, jackets, etc.). Student possessions such a lunch boxes should not display disturbing images that might be scary to young children. Student/Parents are encouraged to clear all questionable items before they are brought to school. This will help us avoid many problems. **SHOES:** must not restrict the students from safely participating in all activities.

Outings and Field Trips: When your child is enrolled we include a permission slip in your packet. If you do not want your child to participate in field trips, please let us know. You will be notified in advance of all field trips. Any field trips out of town will require a special permission slip to be signed.

Discipline Statement: The staff works at knowing each child personally and tries to avoid discipline problems. Problems which do occur in a social situation may be handled by a short time-out period not to exceed one minute per age of child or re-directing the child to another area of interest. We feel it is important to discuss behavior problems with the child, making sure that they understand the situation and the consequence. Learning to cooperate and resolve conflicts in acceptable ways and developing trusting relationships with adults is important to a child's development. Corporal punishment, infliction of pain, humiliation, intimidation, ridicule, mental abuse, or any other actions that might interfere with the daily living functions, including eating and toileting are NOT used at our school.

Inspection authority by Community Care Licensing: Section 101195(b)(c); The department of licensing agency shall have the authority to interview clients including children or staff and to inspect and audit client or facility records without prior consent. The department of licensing agency shall have authority to observe the physical conditions of the client which include possible abuse, neglect, inappropriate placement and to have a licensed medical professional physician examine the client.

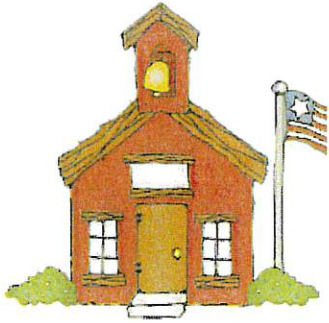
Complaint Procedure: Parents understand they have the right to call or write the licensing agency if fault is found in the operation of facility or treatment of their child. Call or write:

Community Care Licensing

520 Cohasset Road, suite 6

Chico, Calif. 95926

530-895-5033



Great Beginnings Preschool
609 Summer Street
P.O. Box 404
Fortuna, CA. 95540
707-725-9136
LIC # 125406576

TO PARENTS AND GUARDIAN:

The following information is needed for the school records.

Student's full name _____ Age _____

First M Last

Boy Girl Date of Birth _____ Birth Place _____

Physical Address _____
Street City Zip

Mailing Address if Different from Above _____
Street City Zip

E-mail Address _____

Status of Parents: Married Divorced Separated

Name of Father or Guardian _____

Home Phone _____ Cell _____

Employment _____ Business Phone _____

Name of Mother or Guardian _____

Home Phone _____ Cell _____

Employment _____ Business Phone _____

School Last Attended _____
Name Address City State Zip

Other children under 18 years of age living with the family

Name	Birthdate	School Attending
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT, DOMESTIC PARTNER, 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, Domestic Partner or Authorized Representative

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

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER 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/DOMESTIC PARTNER'S NAME		DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/DOMESTIC PARTNER'S NAME		DOES MOTHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS THIS CHILD BEING UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

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

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

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

<input type="checkbox"/> Chicken Pox	DATES	<input type="checkbox"/> Diabetes	DATES	<input type="checkbox"/> Pollomyelitis	DATES
<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? AAAaaa

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/DOMESTIC PARTNER'S SIGNATURE	DATE
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RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

PHYSICIAN'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/DOMESTIC PARTNER, 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) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (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

Photo Release Form

New Life Christian School has my permission to publish my or my child's photograph in the media to promote the school.

_____ New Life Christian School may also use the photographs on the school web site or facebook to promote the school.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name: _____

Child(ren)'s Name(s): _____

TRAVELING PERMISSION SLIP

We, the undersigned and the parents or legal guardians of _____ do hereby give permission for participation in field trips and special events conducted away from the normal premises of this school.

Being fully aware that this school will do everything in their ability to provide safety and assistance for my child, I will not hold New Life Christian School responsible for any injury or physical hurt that might result in the participation of such activities.

Signature of Parent

If you do not want your child to leave the premises for any reason, please note reason and sign here.

Reason:

Signature

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

Licensing Office Address: 520 Cohasset Rd, Suite 170, MS29-05 Chico, Ca. 95926

Licensing Office Telephone #: 530-895-5033

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.

Great Beginnings 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

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 <i>Community Care Licensing</i>		
ADDRESS <i>520 Cohasset Rd, Suite 170, MS 29-05</i>		
CITY <i>Chico, Ca.</i>	ZIP CODE <i>95926</i>	AREA CODE/TELEPHONE NUMBER <i>530-895-5033</i>

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) <i>Great Beginnings Preschool</i>	(PRINT THE ADDRESS OF THE FACILITY) <i>609 Summer St. Fortuna</i>
(PRINT THE NAME OF THE CHILD)	

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)