St. Paul Preschool

2916 McKee Road Merced, CA 95340 (209)383-5672

Preschool Child Information

Child's Name			Birthdate
Name(s) Child Called By			Telephone
Home Address			City, Zip Code
MOTHER		FATHER	
Name	Name	Home Address (if different than above)	Home Phone
Home Address (if different than above)	Home Phone	Occupation	Work Phone
Occupation		Work Phone	
STEP-PARENT		OTHER (RELATIONSHIP TO CHILD)	
Name	Name	Home Address (if different than above)	Phone
Home Address (if different than above)	Phone	Occupation	Work Phone
Occupation	Work Phone		

MUST BE FILLED OUT TO COMPLETE REGISTRATION

Names and Dates of Birth of Brothers and Sisters	Others Living in Child's Home	
Fears of Child	Allergies	
Name of Last School/Daycare Attended	Church Affiliation	Ethnicity
email address:	Do you want your child to nap?	

Registration Information

Is this a new registration? ☐YES ☐NO	Summer ☐	Fall ☐	Both ☐	Date child will start:	
What program will your child participate in?					
M-F Full Day ☐	M-F ¾ Day ☐	M-F Half Day ☐	M, W, F Full Day ☐	M, W, F ¾ Day ☐	M, W, F Half Day ☐
T & TH Full Day ☐	T & TH ¾ Day ☐	T & TH Half Day ☐	There will be a $25.00 fee assessed when there is a change in your child's schedule and a risk of losing his/her spot should there be a reduction in hours/days.		

PARENT'S SIGNATURE Date

--Office Use Only--				
Received By	Date	Amount Paid $	Check #	Date Confirmation Mailed

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Consent for Emergency Medical Treatment

As the Parent or authorized representative, I herby give consent to St. Paul School to provide all emergency medical or dental prescribed by a licensed physician or dentist for my son/daughter_____. This care may be given under whatever conditions necessary to preserve the life, limb or well being of the child named above. My child will be transported by an ambulance or other such vehicle, if necessary. I understand that I must assume responsibility for such emergency medical expenses.

My child has the following medication allergies:

_____

My Child has the following allergies and/or asthma:

_____

In case of a non life-threatening medical condition (sick, fever, vomiting, head lice etc.) while my child is attending St. Paul School, I understand that the following procedure will be followed:

1. The school will contact parent(s): (please list all phone numbers that apply)

Please circle Mother or Father to indicate who should be contacted first.

MOTHER		FATHER	
Name		Name	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager/Other	Cell Phone	Pager/Other

2. If neither mother or father is available, the school will contact these emergency numbers:

OTHER (RELATIONSHIP TO CHILD)		OTHER (RELATIONSHIP TO CHILD)	
Name		Name	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager/Other	Cell Phone	Pager/Other

My Physicians NAME:_____ and phone number_____

_____

pARENT'S SIGNATURE Date

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Preschool/Daycare Admission Agreement

Child's Name_____

This child care facility is licensed by the California State Department of Social Services. This facility is a non-medical care facility, which is normally not allowed to provide medical or nursing care.

1. Basic general services:
    a) To love and care for your child.
    b) Teaching and modeling of Christian values.
    c) A planned activity program including arrangement for utilization of available community resources.
    d) Nutritional morning snack provided daily.
    e) Comfortable and suitable mat provided for nap time. (linens not provided).
    f) Communication with parents on a regular basis.

2. Basic personal services:
    a) Continuous observation, care, and supervision.
    b) Assistance with personal cleaning needs, as required.
    c) Assistance with taking prescribed medications in accordance with physicians' instructions unless prohibited by law or regulation.

3. The visiting policy of the facility is open door at all times.

4. Medical Agreement completed by client or authorized representative shall be provided including:
    a) Health history.
    b) Signed physicians form including immunization record and T.B. clearance.

5. Discontinuation of services: The licensee of the facility may discontinue services for one of the following reasons:
    a) Non-payment of the rate for basic services, including any optional services formally agreed upon, within 30 days of the due date.
    b) Failure to comply with all necessary state and health department regulations.
    c) Inability of the licensee to meet the client's needs.
    d) Change of use of facility.

6. The licensee/administrator of the facility may, upon obtaining prior written and/or documented telephone approval from the licensing agency, stop or discontinue services to client upon three days written notice to quit. The licensing agency may grant approval for discontinuation upon finding good cause. Good cause exists if the client is engaging in behavior which is a threat to the mental and/or physical health and safety of him/herself or a threat to others in the facility.

7. The Department or Licensing Agency shall have the authority to interview children or staff and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any children, or any staff member and for the examination of all records relating to the operation of the facility. The Department or licensing agency shall have the authority to observe the physical condition of the child(ren), including conditions which could indicate abuse, neglect, or inappropriate placement.

8. Basic services are to be paid in advance, due on the 1st of each month. A late fee will be assessed on the 11th of the month. Payments are to be made in the form of check or money order to St. Paul School. A finance charge of 2% will be assessed to overdue balances on the 25th of the month.

9. If rates change, at least 30 days written notice shall be given.

10. I understand that the basic rate for the month set forth by this agreement will be prorated on a weekly basis if I enter during the month.

11. Two weeks vacation credit will be issued upon written request prior to the desired dates, after three consecutive months of enrollment.

12. REFUNDS will be given if stated services are not rendered by the licensee/administrator as agreed upon.

13. (Parent/Guardian)_____ will: pay the monthly rate agreed upon; cooperate with the general policies of the facility; not bring medications, special foods, beverages into the facility without knowledge of the administrator; not be destructive to property of the facility or other clients; provide two weeks written notice of the intent to move from the facility.

My signature below indicates that, as the said "Client" or authorized representative of said client, I understand and have read the provisions of this agreement and enter this agreement voluntarily.

_____

Parent/Guardian Date

_____

Director Date