

2020-2021 Extended Care Options

We have an assortment of drop-in programs available here at the Santa Ynez Valley Presbyterian Preschool.

Early Care: You can drop your child off in the Early Care room anytime between **7:30a.m. and 8:50a.m.** on days that you need the extra care in the morning. The charge is **\$3.75 per ½ hour.**

Extended Care: This program is from **12:00-12:30p.m.** The cost is **\$3.75/day** and will be billed on your following months tuition invoice. Please send a snack for your child to eat during this time.

Lunch Bunch: This program is from **12:00-2:30p.m.** The cost is **\$14.00/day** and will be billed on your following months tuition invoice. You need to send a lunch for your child to eat during this time. They will also play on the playground and/or in the classroom ending with story time.

***If you have pre-signed up for one of these options and don't need it on that day for any reason, you must let us know no later than 9:00a.m. on that day or you will be charged.**

Pre-enrolled Afternoon Care

Bear Care: This program is a contracted service and you must be enrolled a minimum of two days per week. It is billed with your regular preschool tuition each month. We have two pick-up options: **12:00-4:00 p.m. is \$19.00/day; 12:00-5:30 p.m. is \$22.00/day.** You need to send a lunch for your child to eat during this time. This program is our most structured of the afternoon program, with lunch, story time, playground, nap/rest, snack, learning centers, art and indoor free play.

***There are no credits or refunds issued for this program for any reason. A two-week notice is required to change or drop days.**

Additional Prearranged Care

We do have a **drop-in option available for Bear Care if there is space available.** The drop-in rate is **\$23.00/day** and will be billed on your following months tuition invoice.

Santa Ynez Valley Presbyterian Preschool
1825 Alamo Pintado Rd. Solvang, CA
(805) 688-4440 Fax (805) 688-2665
Email: office@syvpps.org
License # 421700345

REGISTRATION FOR FALL-2020

Child's Name: _____

Birth Date: _____ Male Female
(Month) (Day) (Year)

Mother's Name _____ Father's Name _____

Mailing Address: _____ Mailing Address: _____

Home Address: _____ Home Address: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____ Email Address: _____

Person(s) responsible for tuition payment _____

Email Address of person(s) responsible of tuition payment _____

Registration Fee - \$50.00 Paid \$45.00 for second child (Non Refundable)

Yearly Snack Fee – **(WILL BE BILLED WITH 1ST MONTHS TUITION.)**

2-Day Program \$33; 3-Day Program \$38; 4-Day Program \$43; 5-Day Program \$48

Number of Days Per Week (9:00-12:00):	Tuition Per Month (Tuition is prorated over the school year)
_____ 2-Mornings Per Week (Tuesday/Thursday)	<u>\$185.00</u>
_____ 3-Mornings Per Week (Mon/Wed/Fri)	<u>\$270.00</u>
_____ 4-Mornings Per Week M____ T____ W____ Th____ F____	<u>\$340.00</u>
_____ 5-Mornings Per Week	<u>\$430.00</u>
_____ Transition (5 Days Per Week)	<u>\$465.00</u>

Bear Care (Must sign up for two or more days)

Until 4:00 M____ T____ W____ Th____ F____ \$19.00 Per Day

Until 5:30 M____ T____ W____ Th____ F____ \$22.00 Per Day

Partial Scholarships may be available. Forms are available in the office.

“Learning through love gives life.”

SANTA YNEZ. VALLEY PRESBYTERIAN
PRESCHOOL
PO BOX 528 SOLVANG, CA 93464
(805) 688-4440
LICENSE # 421700345

Name of Student: _____

Financial Agreement Regarding Tuition:

I (We) understand that tuition is divided into 9 equal monthly installments September 1, 2020 to the end of May 2021. A prorated amount will be charged for August 27 - 31, 2020 on your September bill. There will be no refunds regardless of vacations, holidays or illness /absence when school is open. Tuition will remain the same regardless of the number of days in the month.

Initial Parent and/or Legal Guardian #1 _____ #2 _____

I (We) understand that tuition is due on the 1st day of each month and is considered delinquent after the 15th of the month. A late charge of \$20.00 will be applied to any account with a balance due after this date AND my child will not be permitted to attend Lunch Bunch, Bear Care, Early Care or Extended Care until the balance is paid in full.

Initial Parent and/or Legal Guardian #1 _____ #2 _____

I (We) agree to contact the Directors if for any reason my family does not anticipate being able to pay the balance in full by the 15th of the month in order to request a special arrangement and/or payment plan.

Initial Parent and/or Legal Guardian #1 _____ #2 _____

I (We) understand that if my family has a past due balance on the 1st of the new month, my child (children) will not be permitted to attend any programs until the past-due balance is paid in full.

Initial Parent and/or Legal Guardian #1 _____ #2 _____

I (We) agree to notify the school two weeks in advance of withdrawal from any program, should such a need arise, or pay the difference.

Initial Parent and/or Legal Guardian #1 _____ #2 _____

Agreement Regarding Attendance, Pick-Ups/Sign-Outs, Forms and Medical Reports

I (We) agree to sign in and out legibly each day using a full name, as required by law.

I (We) acknowledge that children must be picked up by the agreed upon time for the program that we have committed to, which is either (circled) 12:00 pm, 4:00pm or 5:30pm. Optional add-on programs (Extended Care 12:30 or Lunch Bunch 2:30) have the same requirement to pick up on time. A Late Fee of \$5.00 will be charged for every 5 minutes late beginning 5 minutes after pick-up time. The late fee will be added to the monthly tuition statement.

I (We) acknowledge that all entrance forms and medical reports with immunizations must be completed and returned to school prior to the first day of school. Please give emergency phone numbers for parent(s), guardian(s), and other local emergency contacts that are authorized to pick-up your child from our program. It is important that this information be accurate, inclusive and legible. All emergency numbers must be kept current.

I (We) agree to accept all rules and regulations as specified in this agreement as well as the Santa Ynez Valley Presbyterian Preschool Parent's Handbook regarding tuition, late fees, attendance, health, arrival and dismissal.

Date: _____ Name: _____ Signature: _____

Date: _____ Name: _____ Signature: _____

*The staff of the Santa Ynez Valley Presbyterian Preschool is mandated by California Law
to report any suspicion of child abuse.*

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:

Chicken Pox	DATES	Diabetes	DATES	Poliomyelitis	DATES
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
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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	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?

ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
YES	NO	YES	NO

WORD USED FOR "BOWEL MOVEMENT"*

WORD USED FOR URINATION*

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:
YES	NO	YES	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:
YES	NO	YES	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
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Children's Residential Facilities

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

_____ TO PROVIDE 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 WHATEVER
NAME

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

()

Family and Social History

Child's Name _____ Birth date _____

Address _____ City, Zip _____

Home Phone Number _____ Cell _____

Father _____ Age _____ Lives in the Home? _____

Mother _____ Age _____ Lives in the Home? _____

Where does father work? _____ What kind of work? _____

_____ Work phone number _____

Where does mother work? _____ What kind of work? _____

_____ Work phone number _____

Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

Children in the Family _____ Age _____ Grade in School _____

Other Members of the Household, if any

Name _____ Relationship _____ Age _____

Does the child have a room alone? _____ Share with whom? _____

Type of housing? _____ Is there a yard? _____

Neighborhood children? _____ Cared for by others? _____

By whom? _____

Health or Allergy problems? _____

Any special problems or fears? _____

Anything else you feel we should know about your child? _____

Signature _____ Today's Date _____

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

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)

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: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

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

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

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.

EMERGENCY PLAN

We at the Santa Ynez Valley Presbyterian School want to take every precaution to give your child the best possible care, therefore, a disaster plan will go into effect if there is a fire, earthquake, flood, nuclear accident, explosion or chemical accident or spill.

Each child must have two emergency cards on file at the school for staff information. Parents should keep information on these cards current. In case of disaster, your child will be kept at school or, if there is a need, be relocated on the grounds either in the multi-purpose room or the church sanctuary. Each child will be released only to the parent or emergency person listed on the file. In case of medical emergency, the hospital or your physician will be contacted as well as the parent or emergency person listed for the child.

The school Director will contact all emergency agencies to ensure your child has immediate help. All staff will focus on keeping each child calm, comforted and cared for until he/she is released to the parent.

I hereby grant permission for the Director or Acting Director to take whatever steps that may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact the child's physician.
3. Attempt to contact parent through any of the persons listed on the emergency information form you provided.
4. If we cannot contact a parent or the child's physician, we will do any of the following:
 - a) Call another physician, b) Call an ambulance, c) have your child taken to an emergency room in a hospital in the company of a staff member.
5. Any expense incurred under the above will be borne by the child's family.

Signed _____ Date _____

Signed _____ Date _____