Woodland Parent Nursery School

Application for Admission

Mail to: Attn: Membership
655 Fourth Street
Woodland, CA 95695

Email to: mem@woodlandparentnurseryschool.org

For Office Use Only

Term: ☐ FA ☐ SP ☐ SU Year:_____

Child Days: T W TH F

Parent Days: 1st ____ 2nd____ 3rd____

- ☐ Registration Fee (New $50; Returning $15)
- ☐ Materials & Maintenance Fee ($50)
- ☐ First Month
- ☐ Physician Report
- ☐ Emergency Card
- ☐ TB Test (Expires: _____)
- ☐ Pre-Admission History
- ☐ Car Insurance (optional)
- ☐ SB792 compliant
- ☐ Birth Certificate
- ☐ Statement of Health
- ☐ Parent's Rights

CHILD'S FULL NAME _____ _____ _____
FIRST MIDDLE LAST

CHILD'S DATE OF BIRTH _____ NICKNAME (to use in school) _____

HOME ADDRESS _____
STREET

_____
CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

WHO WILL BE THE PRIMARY WORKING PARENT OR GUARDIAN?
☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER

MOTHER OR GUARDIAN FULL NAME_____
ADDRESS AND PHONE (if different from above) _____
CELL PHONE _____
WORKPLACE AND PHONE _____

FATHER OR GUARDIAN FULL NAME_____
ADDRESS AND PHONE (if different from above) _____
CELL PHONE _____
WORKPLACE AND PHONE _____

OTHER FULL NAME_____
ADDRESS AND PHONE (if different from above) _____
CELL PHONE _____
WORKPLACE AND PHONE _____

Enroll myself and my child in WPNS starting: ☐ FALL ☐ SPRING ☐ SUMMER _____ YEAR
I would like my child to attend : ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY

My choices for parent work days are: 1st choice _____ 2nd choice_____ 3rd choice_____

Comments:

(Please sign and date the Parent Contract on the next page.)

Woodland Parent Nursery School Parent Contract

I AGREE to the following:

1. To provide the following registration materials prior to my child's first day of attendance:

All documentation within enrollment package, including but not limited to:

- Physicians' report for my child
- Copy of birth certificate for my child
- Emergency and Medical Release Form
- Negative TB test results for each working adult
- Signed statement of health for each working adult
- Proof of Measles and Pertussis Immunization for each working adult
- Registration Fee & 1st month's tuition

2. To spend the required number of volunteer hours, from 8:30 to 12:30 on assigned days, directly interacting and observing the children in the nursery school. Example of work schedule: for a child attending 2 days a week, parent works 2 days a month plus 1 day per semester.

3. To secure another member to substitute when my absence is necessary, and repay their time in kind or at the minimum wage rate.

4. *To submit, at the beginning of the school year, proof of auto insurance if driving on field trips.

5. *To give permission for my child to take school field trips off the school grounds. The school will provide adequate adult supervision.

6. The Director has my permission to release my child to the person(s) listed on the emergency card.

7. *To attend the school's evening meetings once a month, plus a four hour Saturday meeting (TBA). Missing a meeting will result in a $50 fine and an extra work day(s). (In the event of an emergency it is possible to avoid this penalty by contacting the director or a board member to discuss.)

8. *To participate in each semester's work party for a minimum of four (4) hours. That is a total of eight (8) hours per year. Missing a work party will result in a $50 fine.

9. To take my turn providing for the weekend cleaning and maintenance of the school. Missing scheduled weekend maintenance will result in a $50 fine.

10. To participate in membership hours for a minimum of two (2) hours each semester. That is a total of four (4) hours per year. Missing a membership hours for a semester will result in a $50 fine.

11. *To meet each semester's fundraising requirement of $200, for a total of $400 per year. This can be bought out or fulfilled in part by the Annual Auction participation or other fundraising events.

12. *To participate in the Annual Auction; sell tickets, solicit donations, donate food to the event and perform committee work.

13. *To have a school job assignment.

14. To allow use of my child's photo or video recording for the sole purpose of WPNS publicity.

15. To pay all tuition, fees and fines by the 10th of the month.

16. To give at least two (2) weeks written notice, and bring all my participation and financial obligations up to date if it should become necessary to withdraw from the School prior to the end of the school year.

17. To have a wonderful time with my child at WPNS!

SIGNED _____ DATE _____

* Not applicable to Summer School

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:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ 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.

VOLUNTEER STATEMENT OF GOOD HEALTH

Woodland Parent Nursery School is a licensed childcare program and is governed by California Community Care Licensing Regulations. These regulations require that all personnel, including parent volunteers, be in good health and shall be physically and mentally capable of performing assigned tasks. This requirement is to ensure the health and safety of children enrolled in licensed childcare program.

State regulations require that the good physical health of each volunteer that works in the center shall be verified by a statement, signed by the volunteer, affirming that they are in good health.

By signing below, I am affirming that I understand the reasons a Statement of Good Health is required and that I am in good health.

I, _____, do affirm that I am in good health.

Signature _____ Date _____

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?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST _____
	LUNCH	LUNCH_____
	DINNER	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

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

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

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

Woodland Parent Nursery School
_____ 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 OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

Woodland Parent Nursery School

655 Fourth Street, Woodland, CA 95695

Medical Authorization Form

I, _____, have placed my child(ren),
YOUR NAME

_____,
CHILD(REN)'S NAMES

with **Woodland Parent Nursery School.**

I hereby authorize the above school to have my child(ren) examined in the event of illness or injury during school placement and to obtain whatever medical care is recommended by a licensed physician.

_____ _____ _____
DATE SIGNATURE RELATIONSHIP

Children's Names: _____

Birthdate(s): _____

Home Address: _____

Emergency Phone Numbers:
Mother: _____ Father: _____

Other adult authorized to pick up your child(ren):
Name: _____ Relationship: _____

Phone Number(s): _____

Physician to be called in emergency: _____

Last Tetanus Shot: _____ Drug Allergies: _____

Food Allergies: _____

_____