



Dear Parents/Guardians,

We are delighted to welcome you to Woodland Parent Nursery School “Rainbow School” (WPNS), a **parent cooperative** where we believe in working together to create a nurturing and engaging learning environment for our children. We can't wait for you to be a part of our close-knit community!

If you haven't had the chance to visit us yet, we would love to schedule a tour for you to see our program in action. Our families and experienced educational director are eager to show you the unique benefits of our cooperative nursery school.

To ensure priority, we kindly request that you submit your completed registration paperwork as soon as possible. We operate on a first-come, first-serve basis, and we wouldn't want you to miss out on the opportunity to join our vibrant community.

To learn more about what WPNS has to offer, please visit our website and don't hesitate to reach out to us at membership@woodlandparentnurseryschool.org with any questions.

Thank you again for considering Woodland Parent Nursery School.



MONTHLY FACILITY FEE

Mulberries Preschool, 2-6 year olds

TUES/THU

8:30 am - 11:30 am — 2 days / week

- **\$160 per month** with in-class family participation

TUES/THU/FRI

8:30 am-11:30 am — 3 days / week

- **\$240 per month** with in-class family participation

Oaks Preschool, 2-6 year olds

MON/WED

8:30 am - 11:30 am — 2 days / week

- **\$160 per month** with in-class family participation

MON/WED/FRI

8:30 am-11:30 am — 3 days / week

- **\$240 per month** with in-class family participation

MON - FRI

8:30 am-11:30 am — 5 days / week

- **\$400 per month** with in-class family participation

Family Participation:

- In-class family participation includes one volunteer day per month, for each day your child attends per week, plus one extra per semester.
- All families including, "Limited Participation," must participate in family education, job assignments, clean up days, etc.

Sibling discount:

- We offer a 10-15% sibling discount for families that have multiple children enrolled.



Woodland Parent Nursery School Application for Admission

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

Email to: hello@woodlandparentnurseryschool.org

For Office Use Only	
Term:	<input type="checkbox"/> FA <input type="checkbox"/> SP <input type="checkbox"/> SU Year: _____
Child Days:	T W TH F
Parent Days:	1 st _____ 2 nd _____ 3 rd _____
<input type="checkbox"/>	Registration Fee (Non-refundable \$50)
<input type="checkbox"/>	Materials & Maintenance Fee (Non-refundable \$50)
<input type="checkbox"/>	First Month Fees
<input type="checkbox"/>	Physician Report
<input type="checkbox"/>	Emergency Card
<input type="checkbox"/>	TB Test (Expires: _____)
<input type="checkbox"/>	Pre-Admission History
<input type="checkbox"/>	Car Insurance (optional)
<input type="checkbox"/>	SB792 compliant
<input type="checkbox"/>	Statement of Health
<input type="checkbox"/>	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 N/A - LIMITED PARTICIPATION

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 _____

Woodland Parent Nursery School Parent Contract

I AGREE to the following:

CARE

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:

- o Physicians' report for my child
- o Emergency and Medical Release Form
- o Negative TB test results for each working adult
- o Signed statement of health for each working adult
- o Proof of MMR and Tdap Immunization for each in-class working adult
- o Pre-Admission History
- o First month's fee
- o Non-refundable Registration Fee
- o Non-refundable Maintenance Fee

2. To provide my child with a nutritious mid-morning snack, appropriate attire, and backup clothing.

3. To pick up my child from the center promptly at the end of the school day.

4. To sign my child into school using the child and adult's first and last names and time of arrival.

5. To sign the child out of school using the child and adult's first and last names and time of departure.

6. To notify the school when the child is absent.

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

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

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

PARTICIPATION

10. To spend the required number of volunteer hours, from 8:00 to 12:00 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.

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

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

13. To attend the school's evening meetings five times a year. We also have four Saturday socials. 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.)

14. 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.

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

16. 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.

17. 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.

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

19. To have a school job assignment.

FEES

20. We are a parent cooperative, monthly fees go to the use and maintenance of the facility and parent/family education.

21. To pay all fees and fines by the 10th of the month.

22. 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.

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

TERMINATION OF THE AGREEMENT

This agreement shall be terminated if any one of the following occurs:

24. The school year has come to an end.

25. Serious and/or prolonged illness has prevented the child from attending.

You will be given at least 30 days notice before any changes are made to this agreement.

PRINTED _____

SIGNED _____ 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)

Woodland Parent Nursery School . This Child Care Center/School provides a program which extends from 8 :30
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 11:30 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.



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*	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

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					BUSINESS TELEPHONE ()
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE ()
LAST					MIDDLE
FIRST					BUSINESS TELEPHONE ()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					BUSINESS TELEPHONE ()
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE ()
LAST					MIDDLE
FIRST					BUSINESS TELEPHONE ()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					BUSINESS TELEPHONE ()
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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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: _____