Santa Ynez Valley Presbyterian Preschool

1825 Alamo Pintado Rd., Solvang, CA 93463

Phone: (805) 688-4440 Fax: (805) 688-2665

Email: office@syvpps.org Website: syvpps.org

License #: 421700355 Tax ID: 77-0067797

New Student Registration Packet

Please return all forms attached at the time of registration. All SYVPPS students must have current physician's reports and immunization records prior to the first day of school. If you have an appointment scheduled over the summer, please provide the school with the physician's report and updated immunization record at school orientation.

Registration Form Checklist:

____ Date of Enrollment

____Registration Page

____Financial Contract

____Child's Preadmission of health

____Identification and Emergency Information

____Emergency Plan

____Consent for Emergency Treatment

____Family and Social History

____Parents' Rights

____Personal Rights

____Physician's Report

____Immunization Records

____Photo Release

____Call Multiplier Form

____Known Allergies?_____(please write none or list allergy)

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

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?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
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

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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

EMERGENCY PLAN

The Santa Ynez Valley Presbyterian Preschool wants 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 an emergency plan form 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. If needed, Ballard School is our alternate site. Each child will be released only to the parent or emergency contact listed on the form. In case of medical emergency, the hospital or your physician will be contacted as well as the parent or emergency contact listed for the child.

The school director will contact all emergency agencies to insure 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 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 a parent through any of the persons listed on the emergency information for 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_____

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

AS THE PARENT 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 OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

Family and Social History

Please help our staff better serve your child and family by answering the following questions. This information is strictly confidential and will be made available to the teaching staff and director of the center only. We want to thank you in advance for taking the time to give us this valuable information.

Child's Name: _____ **Birth date:** _____
Address: _____ **City:** _____
Home Phone Number: _____ **Zip:** _____
Father: _____ **Occupation:** _____
Mother: _____ **Occupation:** _____
Marital Status: Married_____ **Separated**_____ **Divorced**_____ **Widowed**_____ **Single**_____

Child's Information

1. Name a few activities that your child enjoys:_____
   _____
2. Does your child prefer to play alone or with other children?_____
3. How does your child handle separation from you?_____
   _____
4. If your child has separation issues, how can the staff be of help to you?_____
   _____

Family Information

1. List all people living in your home; include names, ages and relationship to the child:_____
   _____
2. What languages are spoken in the home?_____

Child's Needs

1. Was your child premature or faced health difficulties when born? If so, what were they?_____
   _____
2. Does your child have any behaviors that we should be aware of? Ex: biting, thumb sucking, tantrums, Etc... _____
3. Does your child have any allergies, speech or hearing challenges or any other special need or condition we should be aware of? _____
   _____
4. What type of soothing techniques work best with your child when he or she is tired, upset, hurt or just needs some comforting?_____
   _____
5. Is your child going through any type of stress that we should be aware of? New house? New Sibling? Death in the family? Divorce? Loss of a pet? Other?_____
   _____
6. Is there anything else that you would like us to know about your child? _____
   _____

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: Department of Social Services-Community Care Licensing

   Licensing Office Address: 6500 Hollister Avenue, Suite 200, Goleta, CA 94117

   Licensing Office Telephone #: 805 562-0400

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.

Santa Ynez Valley Presbyterian 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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

Department of Social Services - Community Care Licensing

ADDRESS

6500 Hollister Ave. Suite 200

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Goleta, California	93117	805-562-0400

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)
Santa Ynez Valley Presbyterian Preschool	1825 Alamo Pintado Road Solvang, Ca 93463

(PRINT THE NAME OF THE CHILD)

SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter _____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____ 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: _____

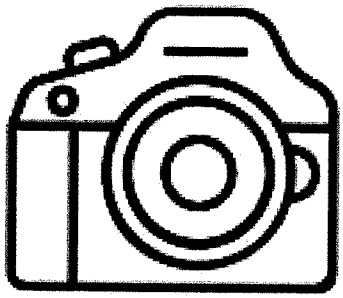
Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☑ 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.



2022-2023 SYVPPS Photo Release

The staff at SYVPPS will occasionally take pictures of students throughout the year for use in our classroom projects and school slideshow presentations. These images would only be used on the password-protected photos page of the school website. PHOTOS ARE NEVER USED ON SOCIAL MEDIA OR IN ADVERTSING!

___**YES,** I GIVE YOU PERMISSION TO TAKE MY CHILD'S PICTURE FOR CLASSROOM PROJECTS AND SCHOOL SLIDESHOWS.

___**NO,** I DO NOT GIVE YOU PERMISSION TO TAKE MY CHILD'S PICTURE FOR CLASSROOM PROJECTS AND SCHOOL SLIDESHOWS.

EMERGENCY TEXTING SYSTEM

Dear Parents,

At SYVPPS, we have an emergency texting system in place called Call Multiplier. We only will use this system in the event of an emergency situation (sudden school closing, fires, lockdowns, etc.). You may add up to four (4) emergency contacts in our system for each student. Please let your family/friends know that you have placed them on this list so that they don't think it is spam if they receive a text. Please turn this paper into your teacher or to the office asap. **PLEASE PRINT CLEARLY!** Thanks!

1. _____ _____
   Parent #1 Cell Number

2. _____ _____
   Parent #2 Cell Number

3. _____ _____
   Printed Name-Contact #3 Cell Number

4. _____ _____
   Printed Name-Contact #4 Cell Number

_____ _____
Student Name (Printed) Date

_____ _____
Parent/Guardian Name (Printed) Parent/Guardian Signature

Dear Parent or Guardian,

The Healthy Schools Act of 2000 requires that all child care centers provide parents or guardians of students with annual written notification of expected pesticide use at the center. The notification will identify the active ingredient or ingredients in each pesticide product and will include the Internet address (http://www.cdpr.ca.gov) for further information on pesticides and their alternatives.

Parents or guardians may request prior notification of individual pesticide applications at the center. People listed on this registry will be notified at least 72 hours before pesticides are applied. If you would like to be notified every time we apply a pesticide, please complete and return the form below

If you have any questions, please contact Santa Ynez Valley
Presbyterian preschool
1825 Alamo Pintado Rd.
Solvang, Ca 93463

Sincerely,

Rhonda Grael

Request for Individual Pesticide Application Notification

I understand that, upon request, the child care center is required to supply information about individual pesticide applications at least 72 hours before application. I would like to be notified before each pesticide application at this center.

I would prefer to be contacted by (check one): U.S. Mail _ E-mail ___ Phone___

Please print neatly:

Name of Parent/Guardian: _____Date: _____

Address: _____

Day Phone:( )_____ Evening Phone:( )_____

E-mail:_____

Return to:

2022-2023
Extended Care Options

Early Care: Early Care is a drop-program and can be used as needed with no reservation. 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**.

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 $25/day; 12:00-5:30 p.m. is $28.00/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.**