Santa Ynez Valley Presbyterian Preschool
1825 Alamo Pintado Rd. Solvang, CA 93463
(805) 688-4440 Fax (805) 688-2668
E-Mail: office@syvpps.org
License # 421700345

REGISTRATION FOR FALL – 2026-2027 SCHOOL YEAR

Child's Name: ____

Birth Date: ______________________ Male__________ Female__________
(Month) (Day) (Year)

Allergies:______________________________

Mother's Name:______________________ Father's Name:______________________

Mailing Address:______________________ Mailing Address:______________________

______________________ ______________________

Home Address:______________________ Home Address:______________________

______________________ ______________________

Cell Phone: ______________________ Cell Phone: ______________________

Email:______________________ Email: ______________________

Email of person(s) responsible for tuition payment: ______________________

Registration Fee - $50.00/$45.00 for second child (non-refundable)

Yearly Snack Fee: 3 day program $75.00 4-5 day program $100.00

***Registration Fee is due with application Snack Fee will be billed with your first month's tuition.**

Tuition per Month: (Tuition is prorated over the 10 month August 2026 - May 2027 school year)

- Early drop off begins as early as 7:45 and runs until 9:00am
- Extended day runs 12:00-5:00pm each day Monday through Friday

9:00-12:00 Option per Month:		**9:00-1:00 Option per Month:**		**9:00-5:00 Full Day Option per Month:**	
_____3-Days per Week (MWF)	$350	_____ 3-Days per Week	$470	_____ 3-Days per Week	$830
_____4-Days per Week (M-Th)	$450	_____ 4-Days per Week	$610	_____ 4-Days per Week	$990
_____5-Days per Week	$550	_____ 5-Days per Week	$750	_____ 5-Days per Week	$1150

7:45-12:00 Option per Month:		**7:45-1:00 Option per Month:**		**7:45-5:00 Full Day Option per Month:**	
_____3-Days per Week	$455	_____3-Days per Week	$650	_____ 3-Days per Week	$890
_____4-Days per Week	$575	_____4-Days per Week	$800	_____4-Days per Week	$1120
_____5-Days per Week	$695	_____5-Days per Week	$950	_____5-Days per Week	$1350

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

* A Convenience Fee of 1.5% will be added for online QuickBooks payments.

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Name of Student:____

Financial Agreement Regarding Tuition:

I (We) understand that tuition is divided into 10 equal monthly installments August 2026 to May 2027. 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 5th of the month. A late charge of $30.00 will be applied to any account with a balance due after this date.

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 10th of the month to request a special arrangement and/or payment plan.

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, 1:00 pm or 5:00 pm. A **Late Fee** of $15.00 will be charged beginning 5 minutes after pick-up time. The late fee will be added to the monthly tuition invoice and $1 for every additional minute. Please contact the office immediately when you are running late.

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 number for parent(s), guardian(s), and other local contacts who 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 the agreement, I have read the Santa Ynez Valley Presbyterian Preschool Parent's Handbook regarding tuition, late fees, attendance, health, arrival, and dismissal and agree to accept all rules and regulations therein.

Date:__________________ Name:__________________________________ Signature:___________________________

Date:__________________ Name:__________________________________ Signature:___________________________

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________________________

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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 (8/08)

(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

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 (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
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: ________________

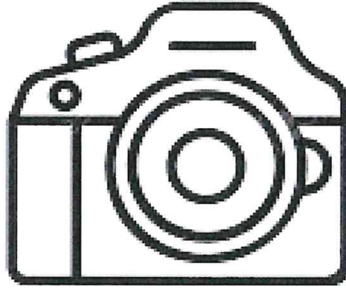
Signature ________________

☑ 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.



2026-2027 SYVPPS Photo Release

The staff at SYVPPS will occasionally take pictures of students throughout the year for use in Look what I did "what's going on", our classroom projects and school slideshow presentations.

___**YES,** I GIVE PERMISSION FOR MY CHILD'S IMAGE TO BE USED ON INSTAGRAM/FACEBOOK

___**YES**, I GIVE YOU PERMISSION TO TAKE MY CHILD'S PICTURE FOR CLASSROOM PROJECTS AND SCHOOL SLIDESHOWS ALONG WITH ON OUR PASSWORD PROTECTED WEBSITE.

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

______________________________	______________________________
Students Name	Date
______________________________	______________________________
Parent/Guardian Name (Printed)	Parent/Guardian Signature

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