NORTH KERN CHRISTIAN SCHOOL

Association of Christian School International Member School

710 Peters St., Wasco, CA 93280 (661) 758-5997 FAX (661) 758-4370 nkcs@northkernchristian.org

Dear Prospective Parent,

Thank you for choosing NKCS Preschool! Enclosed you will find an Application of Enrollment, a Tuition & Policies Agreement and a Price List. Please fill out the forms and return them to the school at your earliest convenience, the Price List is to keep for your records. Below I have listed the steps you will need to follow to fully enroll your child in preschool:

1. Upon returning with your completed paperwork the next step you will need to take is to pay our registration fee. Our annual registration fee is $70 if enrolling before our Christmas break and $35 if enrolling after our Christmas break and is non-refundable. Once the registration fee has been paid your child's spot is secured in our preschool.
2. You will then be given a set of state required documents to fill out. One of those documents is a Physician's Report. This form will need to be filled out by your family doctor, please be sure they complete the entire form before leaving the doctor's office. If your child has had a physical in the last year, the doctor may fill out the form based on that physical without needing a new appointment.
3. You will also need to bring in a current copy of your child's immunization records (yellow card), and proof of a TB skin test. The skin test must have been performed within the last year.
4. You will need to read and complete ALL forms thoroughly and return them to the school BEFORE the date you would like your child to start school!

If you would like to visit the preschool, observe the teachers or speak with me about enrolling your student, please call ahead and make an appointment. This will insure I am available to show you around and answer your questions. The best time for an appointment is between 9am and 11am and 3 pm to 5pm, when the students are not eating our napping, so you can observe their daily activities. We are excited to take part in the lives of your little ones and look forward to having him/her in our school. Thank you for your interest in our school we look forward to ministering to your family.

Sincerely,

Jennifer Hill

Jennifer Hill, Director
NKCS Preschool

NKCS Preschool

710 Peters Street
Wasco, CA 93280
661-758-6889
LIC # 150405029

APPLICATION OF ENROLLMENT

Date of Application _____

Child's Full Name

_____
(Last) (First) (Middle)

Name child should go by and learn to spell in the classroom

_____

Address _____
(Street) (City) (Zip Code)

Birth date _____ Age _____ Boy _____ Girl _____

Desired days for applicant's attendance: (please circle one)

Pick Up Times: Full Day(5:15) School Day(3:30) Half Day(12:15)

# of Days _____

Enrollment needed for: Fall _____ Spring _____
Parent/Guardian #1
Mr./Mrs./Ms/ Name _____ Home Phone: _____
Home Address :_____ Cell Phone : _____
Email Address:_____
City/State/Zip :_____ Lives with Student? Yes / No
Relationship to Student:_____ Billing Party? Yes / No
Employer/Occupation : _____ Work Phone: _____

(Information continued on the back of this form)

Parent/Guardian #2

Mr./Mrs./Ms/ Name _____ Home Phone: _____

Home Address :_____ Cell Phone : _____

Email Address_____

City/State/Zip :_____ Lives with Student? Yes / No

Relationship to Student:_____ Billing Party? Yes / No

Employer/Occupation: _____ Work Phone: _____

Siblings currently attending NKCS (list names & grade)

_____

_____

_____

How did you hear about North Kern Christian Preschool?

_____

_____

_____

If your family presently attends church, please give the church name, pastor, and how long you have attended the church:

_____

_____

(Church name) (Pastor) (How long attending?)

Has your child ever been in an early education center before? Yes _____ No _____

If yes, where?

_____

_____

Does your child have special physical conditions/allergies that we should be aware of?

Yes_____No _____ If yes, explain

_____

_____

_____

Please list any other information which you feel would be helpful to the Director before your child is admitted:

_____

_____

_____

_____

State Licensing Requirements:

1. "Community Care Licensing shall have the authorization to interview my child, or the staff, and to inspect and audit my child or facility records without my prior consent. The licensee shall make provisions for private interviews with my child or staff member; and for the examination of all records relating to the operation of the facility." (Community Care Licensing may or may not allow a staff person to be present during the interview.)

2. "The Department or licensing agency shall have authority to observe the physical condition of my child without my prior consent, including conditions which could indicate abuse, neglect, or inappropriate placement and to have a licensed medical professional physically examine the child(ren)." As the parent(s)/guardian of _____ I/We understand the Department requires my/our signing this form for my/our child to attend this facility. Also, I certify that all information pertaining to the enrollment of my child is accurate. I/We also acknowledge the electronic payment stipulation as outlined above and agree to the terms specified.

_____ _____

Date Mother/Guardian Signature Date Father/Guardian Signature

_____

Date Director's Signature

_____

For Office Use Only, please do not write below line.

Registration/Activity Fee: _____ (non-refundable)

Day(s) and Time attending: _____ Tuition/Day Care Charges: _____ per month

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/DOMESTIC PARTNER'S NAME		DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/DOMESTIC PARTNER'S NAME		DOES MOTHER/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?)

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/DOMESTIC PARTNER'S SIGNATURE	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)

_____. 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/DOMESTIC PARTNER,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 Practioner

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.

California Department of Health Services • Immunization Branch • 2115 Berkeley Way • Berkeley, CA 94704

IMMUNIZATION REQUIREMENTS FOR CHILD CARE

Parents must present their child's Immunization Record prior to enrollment. Acceptable copies are the yellow California Immunization Record, PM-298, or the Immunization History filled out by the physician on Physician's Report-Child Care Centers, LU 701.

Here are the immunizations (shots) required to attend child care, by age:

AGE WHEN ENROLLING	IMMUNIZATIONS (SHOTS) REQUIRED
2 – 3 months	1 each of Polio, DTP, Hib, Hep B
4 – 5 months	2 each of Polio, DTP, Hib, Hep B
6 – 14 months	3 DTP 2 each of Polio, Hib, Hep B
15 – 17 months	3 DTP 2 each of Polio and Hep B 1 MMR; must be on or after the first birthday At least 1 Hib given on or after the first birthday (regardless of any doses given before the first birthday)
18 months – 4 years	3 Polio 4 DTP 3 Hep B 1 MMR; must be on or after the first birthday At least 1 Hib given on or after the first birthday (regardless of any doses given before the first birthday) 1 Varicella

DTP: Diphtheria, tetanus and pertussis combined vaccine. Record may show DTP, DT, or DTaP.
Hib: Haemophilus influenza type B vaccine.
MMR: Measles, mumps, rubella combined vaccine.
Hep B: Hepatitis B. Required as of August 1, 1997
Varicella: (Chicken Pox Vaccine) If your child has had chicken pox ask your doctor to note it on your immunization record to meet the requirement.

Children may be admitted who are behind on their immunizations, ***provided*** the child is up-to-date (no shots are currently due). The next shots must be received when they are due.

Exemptions: The law allows a) parents/guardians to elect exemptions to immunization requirements based on their personal beliefs, and b) physicians of children to elect medical exemptions to them. The law does not allow parents/guardians to elect an exemption because the "shot" record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem.

Reference:
Health and Safety Code Sections 120325-120375 (formerly Sections 3380-3390):
California Administrative Code, Title 17 Sections 6000-6075