

WELCOME TO SUNRISE PRESCHOOL

SUNRISE PRESCHOOL ASSOCIATION
Rm 1, 330 Craig Street, Parksville, BC V9P 2G9 (Parksville Elementary School)
Phone (250) 248-8552
Website: www.sunrisepreschool.ca
E-mail: info@sunrisepreschool.ca

FEES FOR THE 2016-2017 SCHOOL YEAR

Registration Fee: total- \$45.00

Includes Registration+Earthquake+Membership Fee Payable to ***Sunrise Preschool Association*** at time of registration to ensure the spot is held for your child.

Registration fees are not refundable.

One month notice (from the 1st of the month) **must be given in written form or one month's fees will be withheld in lieu of notice if a parent chooses to withdraw child from the preschool.**

If the preschool has an unscheduled closure, then returning parents will be reimbursed for the time during which the preschool was closed. Non-returning parents will not be reimbursed

Preschool Fees:

Monday/Wednesday/Friday 8:30 – 11:00 AM

\$175.00/month

This fee is based on the annual rate of \$1,750.00 and divided into monthly installments for your convenience.

Tuesday/Thursday 8:30 – 11:00 AM Class Fees:

\$130.00/month

This fee is based on the annual rate of \$1300.00 and divided into monthly installments for your convenience.

Tuesday/Wednesday/Thursday 12:00 – 2:30 PM Class Fees:

\$175.00/month

This fee is based on the annual rate of \$1,750.00 and divided into monthly installments for your convenience.

Please have ALL cheques made out to ***Sunrise Preschool Association***, dated for the first day of each month from September, 2016 to June, 2017 and handed in with your registration package.

SUNRISE PRESCHOOL REGISTRATION FORM

CLASS TO BE ENROLLED IN (please circle one) MWF TTh TWT

NAME OF FACILITY **SUNRISE PRESCHOOL** DATE OF ENROLLMENT YYYY / MM / DD

CHILD

NAME OF CHILD
SURNAME GIVEN MIDDLE NAME

NAME CHILD RESPONDS TO SEX: M F

ADDRESS LANGUAGE SPOKEN AT HOME

DATE OF BIRTH YYYY / MM / DD FIRST DAY OF ATTENDANCE YYYY / MM / DD END DATE YYYY / MM / DD

PARENT/GUARDIAN

NAME
HOME ADDRESS PHONE CELL PHONE
MAILING ADDRESS PROV P/C
EMAIL ADDRESS HOURS OF WORK
PLACE OF WORK PHONE LOCAL

NAME
HOME ADDRESS PHONE CELL PHONE
MAILING ADDRESS PROV P/C
EMAIL ADDRESS HOURS OF WORK
PLACE OF WORK PHONE LOCAL

MEDICAL INFORMATION

FAMILY DOCTOR PHONE
MEDICAL SERVICES PLAN # (care card) DATE EFFECTIVE YYYY / MM / DD

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

NAME PHONE
RELATIONSHIP CELL PHONE
NAME PHONE
RELATIONSHIP CELL PHONE

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

NAME PHONE CELL PHONE
NAME PHONE CELL PHONE
NAME PHONE CELL PHONE

PERSONS NOT PERMITTED ACCESS TO CHILD

NAME PHONE
NAME PHONE

ARE THERE CUSTODY ORDERS? YES NO IF YES, ATTACH DOCUMENTATION

NAMES OF OTHER CHILDREN LIVING AT HOME

NAME DATE OF BIRTH YYYY / MM / DD
NAME DATE OF BIRTH YYYY / MM / DD

HAS CHILD HAD PREVIOUS EXPERIENCE AWAY FROM HOME? (DAY CARE, PRESCHOOL, SUNDAY SCHOOL, ETC.) YES NO

IF YES, EXPLAIN: _____

WHERE? _____ DATES OF ATTENDANCE: _____

DO YOU THINK YOUR CHILD FEELS COMFORTABLE LEAVING PARENTS? YES NO
 EXPLAIN: _____

DOES THIS CHILD HAVE ANY KNOWN HEALTH PROBLEMS/MEDICAL DISABILITIES? YES NO
 IF YES, ATTACH DOCUMENTATION _____

HAS YOUR CHILD RECEIVED PROFESSIONAL HELP? (ie: Physiotherapy, Infant Development Services, etc.)
 PLEASE EXPLAIN _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DEVELOPMENT?
 (ie: Hearing, Vision, Language Skills, Socialization with other children, Motor Development)
 PLEASE EXPLAIN _____

LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD: _____

HAS HE/SHE HAD ANY RECENT ILLNESS? YES NO IF YES, EXPLAIN: _____

ANY ALLERGIES? YES NO IF YES, PLEASE LIST: _____

IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION _____

BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN
 (ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)

First Visit – two months of age: YYYY / MM / DD	Fourth Visit – 12 months of age: YYYY / MM / DD
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Measles
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Meningococcal C Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Second Visit – two months after first visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Haemophilus Influenza Type b (hib)
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Measles, Mumps, Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	
<input type="checkbox"/> Hepatitis B	4 to 6 years of age: YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Third Visit – two months after second visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio	Other Immunizations:
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	YYYY / MM / DD
<input type="checkbox"/> Hepatitis B	YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	YYYY / MM / DD

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

NAME OF CHILD _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CHILD RELEASE POLICY

Any child attending Sunrise Preschool will only be released to their parent or alternative adult as listed on the registration form. If another adult is to be picking up your child, the parent or guardian must provide a signed note giving permission for us to release the child into their care. **Verbal permission cannot be accepted.**

If the parent or guardian cannot be contacted in case of emergency, the emergency contact person, as listed on the registration form, will be contacted to pick up your child.

If there is no emergency contact on the registration form, or the emergency contact person also cannot be contacted, your child will remain with the ECE Teacher for 4 hours. If the parent or emergency contact still cannot be reached, the child will be released to the Ministry for protective custody.

If any authorized person (parent, guardian or other) does not arrive to pick up the child, or appears to be incapable of providing safe care (under the influence of drugs or alcohol), Sunrise Preschool will NOT release the child to that person. The emergency contact person or other authorized person, as listed on the registration form, will be contacted for pick up. If an authorized alternative person cannot be contacted, the child will be released to the Ministry for protective custody.

Signature of Parent/Guardian

Date

REFUND POLICY

Registration fees are not refundable.

One month notice must be given in written form or one month's fees will be withheld in lieu of notice if a parent chooses to withdraw child from the preschool.

If the preschool has an unscheduled closure, then returning parents will be reimbursed for the time during which the preschool was closed. Non-returning parents will not be reimbursed.

Signature of Parent/Guardian

Date

PROFESSIONAL DEVELOPMENT POLICY

It is important that the staff at Sunrise Preschool stay current with new developments and best practices in Early Childhood Education. If the center must be closed for the staff to attend a conference/workshop one months notice will be given.

Signature of Parent/Guardian

Date

FIELD TRIP PERMISSION SLIP

Full Name of Child _____

It is our policy that we notify parents when we go on a special field trip. This authorization covers all field trips in walking distance

I give permission for my child to participate in local field trips to places within easy walking distance, without prior notice. Yes No

Parent/Guardian Full Name (Print) _____

Signature of Parent/Guardian

Date

PHOTO RELEASE

Pictures are taken of the children, in groups and individually, while in the classroom, during outdoor play and on fieldtrips. Please indicate below the ways in which your child's image may be used.

- In classroom / year end CD. Thank you cards to donors For advertising purposes.
 Email to individual classes (field trips/classroom activities). Secure online photo server (password protected).

Should you prefer your child not have their photo taken please advise the ECE.

Signature of Parent/Guardian

Date

DEVELOPMENTAL CHECK LIST AUTHORIZATION

Sunrise Preschool strives to provide high quality education and care. To help us do this we ask for your permission to fill out a developmental check list. This allows us to know your child's attributes better. Copies of the check list are available upon request.

By signing this you agree to allow a developmental check list to be done for your child.

Signature of Parent/Guardian

Date

RELEASE OF INFORMATION REQUEST

To provide continuity of education practices that best serve your child we request authorization to share information with our child's Elementary School if they request it.
By signing you give permission for us to provide pertinent information to your child's education.

Signature of Parent/Guardian

Date

SUNRISE PRESCHOOL ASSOCIATION
Rm 1, 330 Craig Street, Parksville, BC V9P 2G9 (Parksville Elementary School)
Phone (250) 248-8552
Website: www.sunrisepreschool.ca
E-mail: info@sunrisepreschool.ca