

WELCOME TO SUNRISE PRESCHOOL

SUNRISE PRESCHOOL ASSOCIATION
502 Bay Ave, Parksville, BC V9P 1C7
Phone (250) 248-8552
Website: www.sunrisepreschool.ca
E-mail: info@sunrisepreschool.ca

FEES FOR THE 2024-2025 SCHOOL YEAR

Registration Fee: total - \$50.00 Includes Registration, Earthquake, Membership Fee

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 – 12:30 PM: 4 hours per day (4 years old by December 31st)

\$375.00/month

This fee is based on the annual rate of \$3,750.00 and divided into monthly installments for your convenience.

Tuesday & Thursday 8:30 – 11:00 AM Class Fees: 2.5 hours per day (3 years old by December 31st)

\$200.00/month

This fee is based on the annual rate of \$2000.00 and divided into monthly installments for your convenience.

Tuesday & Thursday 12:00 – 2:30 PM Class Fees: 2.5 hours per day (3 and 4 year old class)

\$200.00/month

This fee is based on the annual rate of \$2000.00 and divided into monthly installments for your convenience

Registration is on a first come first served basis and will be confirmed via email upon receipt of the completed registration package, \$50 Registration fee and the initialled Payment Policy.

SUNRISE PRESCHOOL REGISTRATION FORM

CLASS TO BE ENROLLED IN (please circle one) MWF TTh AM TTH PM

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 for >30 days, 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

PAYMENT POLICY *Please choose one:*

All 10 cheques are included (post-dated for the 1st of each month September-June)
Cheques made out to Sunrise Preschool.

initial

OR

I prefer to utilize Etransfer for payments and understand that payments must be paid in full on or before the 1st of each month or a late fee will be charged.

initial

OR

I am applying for Affordable child care benefit and have included 2 cheques (Sept & Oct)
Please ensure the Benefit is applied for in a timely manner

initial

OR

I am applying for Affordable child care benefit & understand that FULL Fees must be Etransferred on the 1st of each month until approval of ACCB
Please ensure the Benefit is applied for in a timely manner

initial

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 month's 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 ☐ Newsletters ☐ Storypark (documenting and supporting children's learning together)

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 your 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