



Weekday Preschool

Northridge United Methodist Church
9650 Reseda Blvd. Northridge, CA 91324 (818) 886-4949
Office@WeekdayPreschoolNorthridge.com

Dear Parents,

The following checklist is intended to simplify in completing your children's school forms. Please print all forms one sided only. Return checklist with all completed forms.

CHILD'S NAME _____

- 1) Child Information Page
- 2) Identification & Emergency Info
- 3) School activity & Release of Liability
- 4) Admission Agreement
- 5) Consent for Emergency Medical Treatment (Office copy)
- 6) Consent for Emergency Medical Treatment (Classroom copy)
- 7) Disaster Pick-up

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					BUSINESS TELEPHONE
LAST					()
MIDDLE					
FIRST					
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE					()
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE
LAST					()
MIDDLE					
FIRST					
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
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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**CONSENT FOR MINOR TO PARTICIPATE IN SCHOOL ACTIVITY
AND RELEASE OF LIABILITY**

I (We) hereby consent to my (our) minor child, _____
participating in the following school related activity: Off Campus Field Trips for the
period from September 4, 2019 to June 5, 2020

In consideration of the WEEKDAY PRESCHOOL of the NORTHRIDGE UNITED METHODIST CHURCH ("School") providing the adult-supervised activity described above and for other valuable consideration, I (We) hereby release Weekday Preschool and its agents and employees from any and all liability, claims, demands, actions and causes of actions to accrue to the named minor or to the parents or guardians of the minor as a consequence of any accident or injury. We further hereby expressly agree to indemnify Weekday Preschool and each of its employees and agents and hold them forever harmless against any loss from any and all such claims, demands, action, which may be made or brought by the minor or by anyone acting on behalf of the minor for the purposes of attempting to enforce a claim for damages or on account of injury sustained by the minor or to the minor's property. Such indemnity shall include all reasonable claims, including but not limited to attorney fees.

This release shall inure to the benefit and be binding upon the heirs, assignees, personal representatives, and successors in interest of the parties. Each person signing this executes it on his/her own behalf and on behalf of the child named below. If executed by more than one person it is executed jointly and separately.

Executed at Weekday Preschool of the Northridge United Methodist Church, 9650 Reseda Blvd., Northridge, CA 91324 on _____, 2019

Name of Parent or Guardian:

(Print Name)

(Signature)

Name of Parent or Guardian:

(Print Name)

(Signature)

Weekday Preschool

Admissions Agreement 2019 - 2020 School Year (Office Copy)

This Admissions Agreement is entered into this _____ day of _____, 2019 by and between Weekday Preschool of Northridge United Methodist Church and _____ the Parent(s)/Guardian(s) of _____ whose home address is _____.

The Parent shall pay to the Preschool \$_____ per year for the Basic Services based on the Preschool's rates for such service. The monthly tuition for Basic Services is \$_____. This amount shall be due and payable on the first day of each month, September 2019 through May 2020. The Tuition Deposit paid upon enrollment applies to the June 2020 tuition.

In addition, the parent shall pay \$_____ each month beginning October 2019 for the Optional Service of _____.

I/WE HAVE RECEIVED Copies of the Following: (Please initial)

_____ Weekday Preschool Parent Handbook 2019-2020 (received electronically)

I/WE HAVE RECEIVED the above listed materials and agree to abide by the policies and procedures stated therein.

Signed _____ Date _____
Parent/Guardian

Signed _____ Date _____
Parent/Guardian

Signed _____ Date _____
Debbie Goodman, Weekday Preschool Director

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

Office Copy

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
()

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

Classroom Copy

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:

Blank space for listing medication allergies.

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
()

WORK PHONE
()

