Weekday Preschool

9650 Reseda Blvd, Northridge 818-886-4949
office@weekdaypreschoolnorthridge.com

2024 -2025 REGISTRATION

#

CHILD'S FULL NAME:_____

Non-Refundable REGISTRATION FEE ……...$ **200.00**

TRANSITIONAL KINDERGARTEN: 4 years old as of 9/1/24 (no 2 or 3 day program)

Preschool Regular Day (9:00 -12:00)	**Monthly Tuition**	***Yearly Tuition***
5 days M-F……	$855.00_____	*$8,550.00*

PRESCHOOL: 2 years 6 months to 3 years 11 months as of 9/1/24

-For a child whose birthday is between December 1, 2021 and March 1, 2022, you may only register for T/TH or MWF
. -For children who are entering in Pull-Ups, see Tuition and Fee's Form for updated Tuition.

Preschool Regular Day (9:00 – 12:00)	**Monthly Tuition**	***Yearly Tuition***
5 days M-F……	$855.00_____	*$8,550.00*
3 days MWF……..	$565.00_____	*$5,650.00*
2 days TTH.....	$380.00_____	*$3,800.00*

OPTIONAL PROGRAMS : In August , we will send out a form through Brightwheel to sign up for early morning and/or extended hours . (See Tuition & Fees Form or website for extended fees)

2024-2025 REGISTRATION FORM TOTAL $_____

THIS FORM ALONG WITH THE ADMISSION AGREEMENT CONSTITUTE A COMMITMENT FOR THE 2024-2025 SCHOOL YEAR.

- Your registration paperwork will be emailed to you and completed forms will be due on the day of registration to assure your child's place at Weekday.
- Registration Fees are due at the time of registration and can be paid with cash or check. Deposits will be billed through Brightwheel and can be made by either cash, check (made payable to Weekday Preschool), or through Brightwheel payment.

Parent Signature Date

The following checklist is intended to help ensure that we have all of the enrollment forms for your child.

Please print all forms one sided only.

- ☐ 1) Child Information Page
- ☐ 2) Identification & Emergency Info
- ☐ 3) Pre-Admission Healthy History – Parents
- ☐ 4) Physician's Report (signed and stamped by child's physician)
- ☐ 5) Family Questionnaire
- ☐ 6) School activity & Release of Liability
- ☐ 7) Personal Rights
- ☐ 8) Notification of Parent's Rights
- ☐ 9) Admission Agreement
- ☐ 10) Consent for Emergency Medical Treatment (Office copy)
- ☐ 11) Consent for Emergency Medical Treatment (Classroom copy)
- ☐ 12) Disaster Pick-up

New to Preschool

WEEKDAY PRESCHOOL
9650 Reseda Blvd., Northridge, CA 91324
818.886.4949

2024-2025 Child Information Page

Child's Last Name, First _____ Birth Date _____

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

Home Phone _____

Parent/Guardian _____ Parent/Guardian _____

Cell Phone _____ Cell Phone _____

Occupation and Work Phone _____ Occupation and Work Phone _____

Email _____ Email _____

Child is living with (please circle): Both Parents Mother Father Other

Do other adults live in the home? Yes No

Relationship to child: _____

Siblings Names and Ages: _____

Has the child attended Preschool before? Yes No

Where: _____ How long: _____

Is a language other than English spoken at home? _____

Does your child have allergies? (Please circle one) Yes No
List **allergies** including foods, medications, environmental, **and any food restrictions** for your child on the space below. Additional forms are required. *Your signature at the bottom of this page gives Weekday Preschool permission to post your child's allergy and/or food restrictions at the school.*

_____

Weekday Preschool has my permission to contact my child's physician if questions arise regarding my child's health condition.

Child's and parents' names and email addresses you provide will appear on the classroom roster.

_____ _____
Parent's Signature Date

Child Last Name, First _____

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

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*	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?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
___ YES ___ NO		___ YES ___ NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
___ YES ___ NO		___ YES ___ NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
___ YES ___ NO		___ YES ___ NO	

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

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, 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:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ 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.

Weekday Preschool Family History Questionnaire

This questionnaire will give us information that will help us get to know your family and your child and incorporate the richness of your heritage and culture into our program. We want to share ideas and learn from each family's traditions.

Child's Name: _____ Place of Birth: _____

Mother's Name: _____ Place of Birth: _____

Father's Name: _____ Place of Birth: _____

Mother's Parents live/lived in: _____

Father's Parents live/lived in: _____

Child lives with: _____

Languages spoken at home: _____

Does your family have special customs, traditions, foods you would like to share?

_____

_____

_____

If you would like to come to school and share a favorite song; tell a favorite story; teach a favorite dance; or send in photos, CD, or children's book, please describe what you would like to do:

_____

_____

Are there items of clothing representative of traditional clothing worn by your family that you would like to show us or donate to our classroom for our dramatic play area? If so, please describe:

_____

_____

Please use the back of this page to write more about any of the questions above, or to add anything else you think would be important for us to know about your family heritage or that you would like your child to share with other children in the class.

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:

Community Care Licensing

NAME

6167 Bristol Parkway #400

ADDRESS

Culver City

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
CA	90230	310.377.4333

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)
Weekday Preschool Facility #191202179	9650 Reseda Blvd., Northridge, CA 91324

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

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: Community Care Licensing

   Licensing Office Address: 6167 Bristol Parkway #400 Culver City, CA 90230

   Licensing Office Telephone #: (310) 377- 4333

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

(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.

Weekday Preschool Facility #191202179
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

Weekday Preschool

Admissions Agreement 2024-2025 School Year (Office Copy)

This Admissions Agreement is entered into this_____ day of_____,

2024 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 10 installments for Basic Services are $ _____. This amount shall be due and payable on the first day of each month, September 2024 through May 2025. The Tuition Deposit paid upon enrollment applies to the June 2025 tuition.

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

_____Weekday Preschool Parent Handbook 2024-2025(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:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

Child's Name_____**Child's Birth date:** _____ **Room** _____
(Office use only)

DISASTER PICK-UP AUTHORIZATION 2024 - 2025 SCHOOL YEAR

(For classroom use: please name same individuals as listed on Form LIC 700 as "Authorized Representatives")

In the event of a disaster situation, Weekday Preschool needs to be prepared for unusual circumstances. I/We may not be able to pick up my/our child in a timely manner. Therefore, I/we authorize the following individuals to pick up my/our child from the school:

NAME	PHONE NUMBER	
_____	_____	Cell? Yes or No
_____	_____	Cell? Yes or No
_____	_____	Cell? Yes or No

SPECIFIC PARENTS FROM WEEKDAY WHO ARE KNOWN TO THE WEEKDAY STAFF:

Please release my child to any person listed below after the following time frame:

_____ _____
Immediately **(Indicate how long you would like us to wait)**

_____ _____

_____ _____

EMERGENCY INFORMATION (PLEASE PRINT)

_____ _____
Parent/Guardian Name Best Number to reach you during school hours Cell? Yes or No

_____ _____
Parent/Guardian Name Best Number to reach you during school hours Cell? Yes or No

_____ _____
Home Phone # Cell? Yes or No Alternate Emergency Phone Number Cell? Yes or No

PHYSICIAN'S NAME _____ **PHONE:** _____

IMPORTANT MEDICAL INFORMATION (ALLERGIES, MEDICAL CONDITIONS, ETC.)

_____

_____

_____

_____

_____