Sonshine Pre-school

12229 E. Del Amo Blvd.
Cerritos, CA 90703
(562) 809-6855

REGISTRATION FORM

A registration fee (non-refundable) of $100.00 must be accompanied with this application. This does not assure final enrollment but provides information upon which a decision will be based. Physician's statement signed by a physician and all the required immunizations and health tests must be completed and current by date of admission.

Please Print Clearly

Child's Name: _____ Birth Date: _____

Address: _____ Home #: _____

_____ Male: _____ Female: _____

Cell # Dad: _____ Mom: _____

Work # Dad: _____ Mom: _____

E-mail Dad: _____ Mom: _____

Driver License Dad: _____ Mom: _____

Security Gate Code #: 1) _____ _____ _____ _____

Security Gate Code #: 2) _____ _____ _____ _____

Anticipated Date of Admission: _____

ENROLLMENT

____Full Time: 6:30 a.m. – 6:00 p.m.

____5 half Days: 8:00 a.m. – 12:30 p.m.

____M / W / F: 8:35 a.m. – 11:50 a.m.

____T / TH Half Days: 8:35 a.m. – 11:50 a.m.

Mother (or guardian) Signature: _____

Father (or guardian) Signature: _____

Guardian Signature: _____

Registration Paid Date.: _____

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TUITION RATE

One week advance Tuition required at the **TIME of ENROLLMENT** as a **SECURITY DEPOSIT**.

2023 – 2024 (Sept. – Aug.) Fed. Tax ID: 95-2572418

Program	2023 - 2024	
School Year Registration .....(Sept. – June)	$100.00	
Summer Registration ..... (June – Aug.)	$40.00 /yr.	
Pre-K Materials & Workbook Fees	$100.00	
3 yrs. old Materials & Workbook Fee	$50.00	
Potty Training Assistance	$15.00 /wk.	

Program	2023 - 2024	
Full Time w/ Lunch (Mon. – Fri.) 6:30 a.m. – 6:00 p.m.	$230.00 /wk.	
5 Half Days w/ Lunch (Mon. – Fri.) 8:00 a.m. – 12:30 p.m.	$190.00 /wk.	

Program	2023 - 2024	
M / W / F / Half Days (pre-k.).....(subject to change) 8:35 a.m. – 11:50 a.m.	$110.00 /wk.	
T / Th / Half Days (3 yrs.) .....(subject to change) 8:35 a.m. – 11:50 a.m. (fully potty trained)	$85.00 /wk.	

Prorated Registration Fee	
Enrolling in April to End of School Year	$50.00

Non-Sufficient Fund Check Fee: $25.00

Late Pick up Fee: $5.00 / 5 min.

Rates/Lunch Program are subject to change.

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CONTRACT AGREEMENT

I hereby agree to comply with the rules and regulations of the Sonshine Pre-school fees, attendance, health, parking, clothing, and other items specified in the Parent's Handbook issued by the school. ..... _____**(initial)**

I hereby agree to pay for the entire week of tuition whether my child/ren is/are absent, part of the week, or a full week. I also hereby agree to notify the school two weeks in advance of withdrawal, should such event occur, or pay the difference..... _____**(initial)**

ENROLLMENT STATUS:

____Full Day: Hours my child will be attending school : From _____ a.m. To _____p.m.

____5 half Day ____M / W / F: Half Day ____T / TH Half Day

BI-WEEKLY BILLING PLAN:

The Bi-weekly charge will be posted in your account. However, if you want to submit the payment on weekly basis, you are more than welcome to do so.

PAYMENT METHOD OPTIONS:

Submitting Check or Cash in the office _____

I understand and agree that if I have more than 3 past due status. I will be required to set up 'Automated Payment Billing Plan' (ACH or Credit Card) to continue receiving the childcare service from Sonshine Pre-school. ..... _____**(initial)**

Online Billing Payment (Procare Management Software)

____ * ACH: Automated Clearing House (fee: $1.00/transaction)

____ * Credit Card (fee: 2.79% + .30 cents)

I understand and agree to set up automatic Credit Card Payment plan to make payments if my account has more than 2 INSUFFICIENT FUNDS to continue receiving the childcare service from Sonshine Pre-school.

Tuition rates and transaction fee are subject to change with 30-day notice.

Signature

Mother / Guardian): _____ Date:_____

Father / Guardian): _____ Date:_____

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
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE		FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP		HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE		FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE

PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?

PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE 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 / AUTHORIZED REPRESENTATIVE 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/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE 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.

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SONSHINE PRE-SCHOOL POLICY ON DISCIPLINE

State of California Administrative Code, Title 22, Article 4, section 31239d states clearly that: “Constructive methods must be used for maintaining group control and handling individual behavior. Corporal punishment and other humiliating or frightening techniques are prohibited. Punishment must not be associated with food, rest, isolation for illness or toilet training.”

DISCIPLINARY ACTION

If, or when, behavioral problems exist in your child the following steps will be taken.

1. The teacher will use positive re-enforcement of acceptable behavior.
2. The child will be asked to leave the group (child will remain under observation and supervision of the teacher).
3. With continued misbehavior, the Director will be informed.
4. Director will again use positive re-enforcement and pray with the child.
5. Verbal and/or written communication between teacher and parent, and/or Director and parent (parent co-operation will be required for behavioral modification).
6. After three notices, if all of the above fail to bring the expected level of acceptable behavior over a reasonable period (possibly up to three weeks) and if the school feels that the individual needs of the child are not being met, the parent will receive written notification to withdraw the child from the program.

I have read and agree with the policy on discipline, as defined by Sonshine Pre-school.

Parent’s Signature: _____ Date:_____

Child’s Name: _____ Date of Birth: _____

ALLERGY & FOOD RESTRICTION BRACELET!

If your child has any types of allergy(ies), please come to the office and purchase an Allergy Alert Bracelet for your child.. Your child will be required to wear the bracelet at all times while he/ she is at school. Please DO NOT take the bracelet home. Before leaving, place it in your child’s cubby and put it back on up arriving at school. This is for your child’s safety and to help remind teachers of your child’s allergy(ies).

The cost is $4.00
Thank you!

Name: _____ Purchased Date:_____

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PERMISSION AUTHORIZATIONS

Please Print Clearly

ADMINISTER MEDICATION / MEDICAL CONSENT

As parent or guardian of _____ , I authorize the staff of the Sonshine Pre-school to administer any medications that I may indicate to my child. I authorize the staff of the Sonshine Pre-school to secure and such emergency medical care that my child might required while under the supervision of the school. I also agree to pay all costs and fees that might be incurred on any emergency medical treatment that has been authorized by the school for my child.

Signature: _____

PICTURE & USE

As parent or guardian of _____ , I authorize my child to be included in any pictures taken, and that they may be used as advertising. Any such photography will be administered under the supervision of the school staff and will reflect only the school program of the Sonshine Pre-school.

Signature: _____

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PERMISSION AUTHORIZATIONS (CONTINUED)

Please Print Clearly

ACTIVITIES OFF THE SCHOOL GROUNDS

As parent or guardian of _____ , I authorize and give permission for my child to participate in walking and field trips under the proper supervision of the staff of the Sonshine Pre-school.

I hereby consent to have my child participate in field trips supervised by the teaching staff – away from the school ground to nearby points of interest.

I hereby authorize the Sonshine Pre-school to call an emergency ambulance in case of accident of acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified Physician, called by Sonshine Pre-school may treat and do whatever is necessary for the health and well-being of my child.

It is understood that a conscientious effort must be made to notify me (parents) before such action will be taken.

I also agree to accept responsibility for the cost of above medical services.

Physician's Name: _____ Phone: _____

Address: _____

Mother: _____ Work Phone: _____

Employed by: _____

Address: _____ Occupation: _____

Father: _____ Work Phone: _____

Employed by: _____

Address: _____ Occupation: _____

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

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FAMILY / SOCIAL HISTORY INFORMATION

Please Print Clearly

Child Name: _____ **Birth Date:** _____ **Age:** _____

Name that you would like your child to go by at preschool. _____

List of Food Allergies or Food Restrictions: _____

List of Health Issues: _____

Language Spoken at Home: 1st Language: _____ 2nd Language: _____

Child's Dominant Hand is: Right Hand _____ Left Hand _____ Both _____

Child's Personalities: _____

My child needs help in: Toilet _____ Un/Dressing _____ Eating _____

Other _____ List: _____

Do you have Any Special Concerns Regarding Your Child?

_____

_____

Father's Age: _____ **Mother's Age:** _____

Occupation: _____ **Occupation:** _____

Church Preference: _____ Church Preference: _____

Marital Status: Married/ Living Together: _____ Separated: _____ Divorced: _____ Other: _____

List of Siblings: Brother(s): No _____ Yes _____ (Age): _____

Sister(s): No _____ Yes _____ (Age): _____

If you are a returning student at Sonshine, what is the name of your child's former teacher?

_____

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FAMILY / SOCIAL HISTORY INFORMATION (CONTINUED)

FOR NEW STUDENT ONLY:

How did you hear about Sonshine Pre-school? _____

Has your child had group play experiences? Yes____ Where: _____ No ____

Is your child been attending other daycare center(s) prior to registering at Sonshine? Yes ___ No ____

If yes, List the names of Daycare Centers: _____

What are the reasons for transferring your child to Sonshine Pre-school?

_____

_____

Home Address: _____ _____ _____
Street City Zip

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 Division

   Licensing Office Address: 1000 Corporate Center Dr., Suite 200-B

   Licensing Office Telephone #: Monterey Park, CA 91754

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

LIC 995 (9/08) (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.

Sonshine Pre-school
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

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:

NAME

Community Care Licensing Division

ADDRESS

1000 Corporate Center Dr., Suite 200-B

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterey Park, CA	91754	(323) 981-3350

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)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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