

Circle of Friends Preschool




The two-tsy pop class is a mommy and me program. Mommy's accompany the child to class for the 2 hour session.

Child's Name		Placement #
Birthdate	Name your child goes	Date
Address		Zip
Parent/Guardian 1 Name		Parent/Guardian 2 Name
Home Phone	Parent/Guardian 1 Cell #	Parent/Guardian 2 Cell #

*Enclose your nonrefundable registration fee of \$50.00 and enclose it with your registration forms.

Please designate placement choice

	2 years old by August 31	<input type="checkbox"/> <u>Monday 9:15-11:15</u>	OR	<input type="checkbox"/> <u>Thursday 9:15-11:15</u>
		Class <u>Two-tsy Pops</u>		Session Monday or Thursday
Office Use Only				#
				\$



Student Information Form

Child's Full Name _____ Birth date ____ / ____ / ____

Name your child goes by _____ Gender: Male or Female

Parent/Guardian's Name _____ Relationship _____

Parent/Guardian's Name _____ Relationship _____

Child lives with: _____

Sibling Name _____ Age ____ Sibling Name _____ Age ____

Sibling Name _____ Age ____ Sibling Name _____ Age ____

Family Pets _____

We want your child to have a positive preschool experience. Please help us get to know them by sharing the following information.

1. A brief description of your child's personality: _____

2. Fears your child may have (dogs, sirens, etc.) _____

3. Any unusual experiences your child may have had (moving, hospital stay, loss of someone dear: _____

4. Your child's favorite toys or games: _____
5. Language spoken at home: _____
6. Which is your child's dominant hand? Right Left Undetermined
7. Type of previous group or preschool experience? Yes No Where? _____



Dismissal & Emergency Contact Form

Child's Name: _____

Please list a minimum of two emergency contacts other than parents/guardians. We will make every effort to contact you in the event of an emergency. Should we not be able to get ahold of you, you authorize our staff to contact the following people.

You may also authorize people other than your child's parents/guardians to pick up your child from school. If someone not listed above is picking up your child, they must show their driver's license as identification, which should correspond with the note given to the teacher at the beginning of class. If the information is conflicting, the teacher is not to let the child go until proper confirmation has been made.

For each contact, check the appropriate boxes below. Your parent/guardian information is already on file.

In the event there is a medical emergency involving my child during the school hours at Circle of Friends Preschool, and I am unable to be contacted, I hereby give my permission for appropriate medical treatment to be given to my child by a licensed healthcare professional.

Dismissal Authorization and Emergencies Contacts	Does this person have permission to pick up your child?	Is this person an emergency contact?
Name _____ Phone (____) _____ Relationship _____	Yes No	Yes No
Name _____ Phone (____) _____ Relationship _____	Yes No	Yes No
Name _____ Phone (____) _____ Relationship _____	Yes No	Yes No
Name _____ Phone (____) _____ Relationship _____	Yes No	Yes No
Name _____ Phone (____) _____ Relationship _____	Yes No	Yes No



Medical Release

I (We) the undersigned, parent or legal guardian of _____.

a minor, do hereby authorize and consent for Circle of Friends Preschool to seek medical treatment deemed necessary in the event of an emergency, accident or sudden illness. Every attempt will be made to immediately make contact with a parent.

I (We) will assume any expense incurred by such treatment.

Doctor preferred _____ Phone _____

Hospital preferred _____ Phone _____

Insurance Company _____ Policy Holder _____

Policy Number _____ Group Number _____

I (We) do not hold the above named, or Circle of Friends Preschool responsible or liable for any action necessary in the emergency care of my (our) child.

Signature _____ Date _____

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633
(360) 534-2000
<http://watch.wsp.wa.gov>



WSP Office Use Only

Approval Date: _____

Staff initial.: _____

Expiration Date: _____

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

Student name: _____

Date submitted: _____

Return this form to the director of Circle of Friends Preschool a minimum of two weeks prior to working in the classroom. Include a copy of your driver's license or state-issued identification with this form.

Complete page 1, section A below **and** all of page 2.

SUBJECT INFORMATION: (Please type or print clearly)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name: _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

REQUESTOR INFORMATION: (Please type or print clearly)

DATE: ___/___/___ Sharon Wallenborn, Director _____
Mo Day Yr. (print) Name/Title of Requestor Requestor's Signature

Provide e-mail to receive background results electronically. Phone No. () _____

E-mail address _____ Password (must be at least 8 characters) _____

REQUESTOR'S ADDRESS:

(Please type or print clearly)

Subject's Right Thumb Print (Optional)

Name

Address

City State ZIP Code



Page 2 - of the Washington State Patrol Identification and Criminal History Check

In accordance with RCW 43.43.830, applicants and prospective volunteers are required to complete this disclosure form. In addition, applicants who have been offered employment or volunteer assignments as outlined in said law will be re-quired to complete a Request for Criminal History form, or fingerprinting for a background check. These requests will be forwarded to the Washington State Patrol for disclosure of any applicable charges or finding. Applicants may be employed on a conditional basis pending completion of such background investigation. Volunteers will be retained on the same conditional basis. Answer YES or NO to each listed item. If the answer is YES to any item, explain in the area provided, Indicating the charge or finding, the date and the court(s) involved.

1. Have you ever been convicted of any crimes against persons as defined in Section 1 of Chapter 486, Laws of 1987, and listed as follows: Aggravated murder; first of second degree murder, first of second degree kidnapping; first, second or third degree assault; first, second or third degree rape; first, second or third degree statutory rape; first or second degree robbery; manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment?

ANSWER _____ **If YES, explain** _____

2. Have you ever been found in any dependence action under RCW 13.34.030 (2) (b) to have sexually assaulted or exploited any minor or to have physically abused any minor?

ANSWER _____ **If YES, explain** _____

3. Have you ever been found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor?

ANSWER _____ **If YES, explain** _____

4. Have you ever been found in any disciplinary board final decision to have sexually abused or exploited any minor or to have physically abused any minor?

ANSWER _____ **If YES, explain** _____

5. Have you been convicted in the past 10 years of any crime: felony or misdemeanor?

ANSWER _____ **If YES, explain** _____

Pursuant to RCW 9A.72.085, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. Furthermore, I understand that my continued association with this organization is conditional upon the fingerprinting and/or background checks that Circle of Friends Preschool/Columbia Presbyterian Church will conduct.



ORGANIZATION:
Columbia Presbyterian Church
Circle of Friends Preschool
8715 St. Helens Ave.
Vancouver, WA 98664



I authorize Circle of Friends Preschool/Columbia Presbyterian Church to make investigation of Washington State Patrol Identification and Criminal History Section. I further authorize this government agency to provide Circle of Friends Preschool/Columbia Presbyterian Church with information they have regarding me. I hereby release and discharge the Circle of Friends Preschool/Columbia Presbyterian Church and those who provide information from any and all liability as **a result of furnishing this information.**

Applicant
Signature: _____ Date: _____



Food Allergy/Intolerance Statement

Name of Child _____ Birth date _____

1. Name of Parent/Guardian _____ Phone _____

2. Name of Parent/Guardian _____ Phone _____

We need to know the foods the child is allergic or intolerant to, as diagnosed by a physician, and the treatment steps to take in order to assist in treatment of an allergic reaction.

List each food separately	Food Intolerance	Food Allergy	Symptoms	Treatment (in order of action)
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.
	Yes No	Yes No		1. 2. 3.

By signing below, I indicate my approval for Circle of Friends Preschool staff to assist in treatment of my child's immediate medical need.

Parent's Signature _____ Date _____

Parent's Name _____
(Please Print)

Do you consent to releasing your child's food allergy information to the other preschool classroom parents? Yes No



Emergency Plan for Food Allergic Reactions

ALLERGY TO: _____

Student's Name: _____ D.O.B: _____

Asthma Yes* No *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

<u>Systems:</u>	<u>Symptoms:</u>
• MOUTH	itching & swelling of the lips, tongue, or mouth
• THROAT	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• SKIN	hives, itchy rash, and/or swelling about the face or extremities
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

If symptom(s) are: _____

- Call: Parent/Guardian or Doctor
- Administer with Parental permission: _____ medication/dose/route
- If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

ACTION FOR SEVERE REACTION

If symptom(s) are: _____

- Administer: _____ IMMEDIATELY!
Medication/dose/route
- Call: 911 (Never hesitate to call 911)
- Call: Parent or Guardian

Parent/Guardian _____ phone # _____

Parent/Guardian _____ phone # _____

Doctor _____ phone # _____

Parent Signature: _____



Additional Information

Church affiliation:	Denomination:
Who may we thank for your referral?	

Photo Release

Children will be photographed throughout the school year during the various activities. These pictures may be used in publications for Circle of Friends Preschool and/or Columbia Presbyterian Church, as well as the preschool website (no names listed) and slide shows throughout the school year. Please designate below if your child's picture may be used.

<i>Photos of ALL children will be used in Circle of Friends year-end slide show.</i>	Publications & Website	Private Facebook page
Child's Name _____	Yes	Yes
Parent/Guardian Signature _____	No	No
Date _____		



Circle of Friends Preschool Registration

Student Information

Child's Full Name			Name your child goes by:	
Date of Birth	Age	Gender	Today's Date	

Parent/Guardian Information

Parent/Guardian Information				
Parent/Guardian			Phone ()	
Address	Zip		Cell ()	
Place of Employment			Work phone ()	
Parent/Guardian Information				
Parent/Guardian			Phone ()	
Address	Zip		Cell ()	
Place of Employment			Work Phone ()	

*Email address is for **school** communications only.*

Home E-mail address:
