

CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM
State Requirements for Enrollment
License #376701235

Check that all forms are completed and signed.

| Completed | Description |
|------------------|--|
| | Application |
| | Electronic Payment Authorization |
| | Identification and Emergency Information (LIC 700) |
| | Consent for Emergency Medical Treatment (LIC 627) |
| | Classroom Emergency Information |
| | Medical History |
| | Parents' Contract for Admission of Students |
| | Parents' Rights (LIC 995) |
| | Personal Rights for Children (LIC 613A) |
| | Allergy/Dietary Restrictions |
| | Media Release |

Child's Name: _____
 Last, First

Date: _____



1695 Discovery Falls Drive
Chula Vista, California 91915

619 656 8100 **tel**

619 656 8108 **fax**

www.concordiachurch.com

BEFORE/AFTER SCHOOL PROGRAM APPLICATION

License #376701235

Student Information

| | | | |
|-------------------|--------------------|----------------------------|--|
| Child's Last Name | Child's First Name | Date of Birth (mm/dd/yyyy) | |
| Child's Address | | | |
| City | State | Zip | |
| Referred By | | | |

Parent / Legal Guardian 1

| | | | |
|-------------------|-------------------|-------------------|--|
| Last Name | First Name | Middle Initial | |
| Address | | | |
| City | State | Zip | |
| Cell Phone Number | Home Phone Number | Email Address | |
| Employer | | Work Phone Number | |

Parent / Legal Guardian 2

| | | | |
|-------------------|-------------------|-------------------|--|
| Last Name | First Name | Middle Initial | |
| Address | | | |
| City | State | Zip | |
| Cell Phone Number | Home Phone Number | Email Address | |
| Employer | | Work Phone Number | |

BEFORE/AFTER SCHOOL PROGRAM APPLICATION

Page 2

A \$50.00 nonrefundable application fee must accompany the enrollment form.

Please make check payable to Concordia Church and School.

Prices effective July 21, 2021

| Select Program Option | Program Days | Program Weekly Cost |
|--|-----------------------|---------------------|
| <input type="checkbox"/> Before and After School | Monday through Friday | \$135.00 |
| <input type="checkbox"/> After School Only | Monday through Friday | \$120.00 |

The following information will help us better serve you and your family.

Family Information

| | |
|---------------------------------------|--|
| Are you active military? Yes No | Do you regularly attend a local church? Yes No |
| | Name of Pastor: |

After completing the registration packet, return it and the fee to the School Office in person.

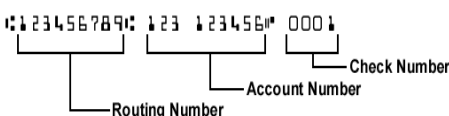
Thank you.

Michelle Schmidt, Director

ELECTRONIC PAYMENT AUTHORIZATION

| | | |
|----------------------------|--------------|------------|
| FOR OFFICE USE ONLY | | |
| Date | Child Number | Child Name |

| | | |
|---|--|---|
| <input type="checkbox"/> Preschool and Child Care Center | <input type="checkbox"/> Before and After School Program | <input type="checkbox"/> Intersession Program |
| Effective date of authorization (mm/dd/yyyy) | | |
| Type of authorization (check all that apply) | | |
| <input type="checkbox"/> New authorization <input type="checkbox"/> Change payment amount <input type="checkbox"/> Change payment date <input type="checkbox"/> Change banking information <input type="checkbox"/> Discontinue payment | | |
| Last Name | | First Name |
| Address | | |
| City | | State Zip |
| Primary Phone | | Email |

| | | | |
|--|--|---------------------------------|--|
| OFFICE USE ONLY | | | |
| Date of first payment (mm/dd/yyyy) | Amount of first payment \$ | Amount of ongoing payment \$ | Date of last payment - optional (mm/dd/yyyy) |
| Please debit payments from my (check one) | Routing Number | | Account Number |
| <input type="checkbox"/> Savings Account (contact financial institution for Routing #) | | | |
| <input type="checkbox"/> Checking Account (attach a voided check below) | | | |
| Check Routing Number Example | ⑈⑈23456789⑈⑈23⑈23456⑈000⑈ | | |
| A Valid Routing # must start with 0, 1, 2, or 3. |  | | |

Monthly payment will be deducted on the 3rd.

I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

| | |
|----------------------|------|
| Authorized Signature | Date |
|----------------------|------|

Please attach a voided check at the bottom of this page.

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 |
|-------------------|-----------|

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

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Concordia Preschool and Child Care

FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

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

()

Before and After School Classroom Emergency Information

Student Information

Today's Date:

| | | | |
|--|--------------------|----------------------------|-----|
| Child's Last Name | Child's First Name | Date of Birth (mm/dd/yyyy) | Age |
| Does your child take any medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, please list medication. | | | |
| List any allergies or special needs your child has. | | | |
| Is there anything else we should know about child? | | | |

Father / Legal Guardian 1

| | | | |
|---------------------|-------------------|-------------------|--------------|
| Last Name | First Name | Middle Initial | |
| Address | | City | State Zip |
| Cell Phone Number | Home Phone Number | Email Address | |
| Employer/Occupation | | Work Phone Number | |

Mother / Legal Guardian 2

| | | | |
|---------------------|-------------------|-------------------|--------------|
| Last Name | First Name | Middle Initial | |
| Address | | City | State Zip |
| Cell Phone Number | Home Phone Number | Email Address | |
| Employer/Occupation | | Work Phone Number | |

All People Who Are Authorized to Pick Up Other than Parents

| | | | |
|-----------|------------|-------|--------------|
| Last Name | First Name | Phone | Relationship |
| Last Name | First Name | Phone | Relationship |
| Last Name | First Name | Phone | Relationship |
| Last Name | First Name | Phone | Relationship |
| Last Name | First Name | Phone | Relationship |
| Last Name | First Name | Phone | Relationship |

Photo Release (check all that apply)

| | | |
|--|--|--|
| I give permission to use my child's photo for the following purpose: | | |
| <input type="checkbox"/> Promotional Materials | <input type="checkbox"/> Classroom Use (art projects, to hang in the classroom and the hall) | <input type="checkbox"/> None at this time |

Official use only.

Classroom: _____

Medical History

Child Information

| | | |
|-----------|------------|------|
| Last Name | First Name | Date |
|-----------|------------|------|

Parent / Legal Guardian 1

| | | |
|-------------------|-------------------|-------------------|
| Last Name | First Name | |
| Cell Phone Number | Home Phone Number | Work Phone Number |

Parent / Legal Guardian 2

| | | |
|-------------------|-------------------|-------------------|
| Last Name | First Name | |
| Cell Phone Number | Home Phone Number | Work Phone Number |

Medical History

Please list your child's medical history including hernias, head injuries, heart disorders, cancer, arthritis, scoliosis, hearing/vision problems, learning difficulties, eating disorders, or other illnesses.

If pre-existing medical conditions may affect participation in daily activities, please have your doctor document these conditions and give approval or agree to discuss the condition with a Concordia School Director.

Parent/Legal Guardian Signature

| | | |
|----------------|-----------------|------|
| Sign Full Name | Print Full Name | Date |
|----------------|-----------------|------|



1695 Discovery Falls Drive
Chula Vista, California 91915

619 656 8100 tel
619 656 8108 fax

www.concordiachurch.com

**CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM
PARENTS' CONTRACT FOR ADMISSION OF STUDENTS**

License #376700616

Parents/Legal Guardians with whom student lives

| | | | | |
|---------------------------------|----------------------------------|------------|-------|-----|
| Father/Legal Guardian Last Name | Father/Legal Guardian First Name | Cell Phone | | |
| Mother/Legal Guardian Last Name | Mother/Legal Guardian First Name | Cell Phone | | |
| Address | | City | State | Zip |

Student Information

| | | | |
|-----------|------------|----------------|---------------|
| Last Name | First Name | Middle Initial | Date of Birth |
|-----------|------------|----------------|---------------|

By my signature on this document, I acknowledge that I am the parent or legal guardian of the above student for whom I have requested admission into the Before and After School Program.

BY RESOLUTION OF THE BOARD OF EDUCATION FOR THE CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM (B/A), THE FOLLOWING STATEMENTS ARE DESIGNED TO BE THE CONDITIONS FOR ADMISSION: In consideration of such admission, I agree to the conditions governing admission and attendance at the B/A, as stated below.

I understand the annual application fee is to be paid in advance to secure my child's space for the schedule I need/desire and that this fee is nonrefundable.

I agree to make tuition and fee payments to the B/A on or before the scheduled dates. Tuition is due and payable each week by automatic electronic withdrawal from a checking or savings account. A \$30.00 insufficient funds fee will be assessed for each payment not honored by the bank. I acknowledge that the B/A may enforce the following penalty: **The B/A may, at its sole option, terminate the enrollment of any student when payment of fees is in arrears and has not been received by the B/A within 30 days unless prior arrangements has been made with the Business Administrator.**

The administration reserves the right to adjust the prices of it programs at the beginning of each academic school year (or at any time deemed necessary); families will be informed of this change as students enroll for the upcoming school year or at least one month before the change takes effect.

I understand there is NO deduction in fees and "make-up" days are not allowed when my child is absent due to B/A closures, holidays, family vacations, or illness.

B/A hours are available from 7:00 am to 5:30 pm. I understand it is my responsibility to ensure my child is picked up every day by his/her assigned departure time. If not, I understand that I will be billed a late fee of \$1.00 per child, per minute or fraction thereof. After three (3) late pick ups per quarter, the child may be put on probation pending a review of the circumstances. Abuse of this may cause the child to be expelled from the program.

I understand that I must give TWO (2) WEEKS WRITTEN NOTICE if my child will be leaving. If written notice is not given, I agree to pay for those two weeks.

PARENTS' CONTRACT FOR ADMISSION OF STUDENTS

Requests for schedule changes will be made in writing and are subject to space availability in the child's classroom. Schedule changes will take effect only at the beginning of a month.

I agree to read and adhere to the policies, procedures, rules, and regulations communicated by the B/A. Violations of the stated rules and regulations may result in expulsion from the B/A.

I agree to allow my child to participate in all B/A functions, including those that are worship related.

I understand that from time to time my child's class may walk along the school/church property or to the park bordering the school during school hours. I give permission for my child to participate with his/her class on such walks outside the classroom.

I understand that if my child's behavior is disruptive to the learning of other students or endangers the safety of other students, and attempts to correct the behavior have been unsuccessful, my child may be removed from the B/A program.

RIGHTS OF CHILD CARE LICENSING:

- a. The Department has inspection authority to enter and inspect a facility without advance notice.
- b. The Department has the authority to interview children or staff, and to inspect and audit child or Child Care Center records without prior consent.

I UNDERSTAND THAT THE DEPARTMENT OF SOCIAL SERVICES OR LICENSING AGENCY HAS THE AUTHORITY TO OBSERVE, INTERVIEW, AND HAVE MY CHILD(REN) PHYSICALLY EXAMINED AT ANY TIME WITHOUT PRIOR CONSENT. AUTHORITY CITED: SECTION 1596.81, HEALTH & SAFETY CODE.

THE LICENSEE SHALL MAKE PROVISIONS FOR PRIVATE INTERVIEWS WITH ANY CHILD(REN) OR ANY STAFF MEMBER AND FOR THE EXAMINATION OF ALL RECORDS RELATING TO THE OPERATION OF THE FACILITY.

THE DEPARTMENT OF LICENSING AGENCY SHALL HAVE THE AUTHORITY TO OBSERVE THE PHYSICAL CONDITION OF MY CHILD(REN), INCLUDING CONDITIONS WHICH COULD INDICATE ABUSE, NEGLECT OR INAPPROPRIATE PLACEMENT AND TO HAVE A LICENSED MEDICAL PROFESSIONAL PHYSICALLY EXAMINE MY CHILD(REN).

My signature below indicates that I fully understand and will abide by the conditions and terms of this contract.

Parent/Legal Guardian Signature

| | | |
|----------------|-----------------|------|
| Sign Full Name | Print Full Name | Date |
|----------------|-----------------|------|

Parent/Legal Guardian Signature

| | | |
|----------------|-----------------|------|
| Sign Full Name | Print Full Name | 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: Mission Valley District Office

Licensing Office Address: 7575 Metropolitan Drive, #110, San Diego, CA 92108

Licensing Office Telephone #: 619-767-2200

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.

Concordia Preschool and Child Care
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

Mission Valley District Office

ADDRESS

7575 Metropolitan Drive, #110

CITY

San Diego

ZIP CODE

92108

AREA CODE/TELEPHONE NUMBER

619-767-2200

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)

Concordia Preschool and Child Care

(PRINT THE ADDRESS OF THE FACILITY)

1695 Discovery Falls Drive, Chula Vista, CA 91915

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

Allergy/Dietary Restrictions

Your child will be participating in daily snacks, parties, and cooking activities. We need to be informed of any allergies or dietary restrictions.

Child Information

| | | |
|-----------|------------|------|
| Last Name | First Name | Date |
|-----------|------------|------|

Parent / Legal Guardian 1

| | | |
|-------------------|-------------------|-------------------|
| Last Name | First Name | |
| Cell Phone Number | Home Phone Number | Work Phone Number |

Parent / Legal Guardian 2

| | | |
|-------------------|-------------------|-------------------|
| Last Name | First Name | |
| Cell Phone Number | Home Phone Number | Work Phone Number |

Allergy and Dietary Restriction Information

| |
|--|
| <input type="checkbox"/> My child DOES NOT have allergies. <input type="checkbox"/> My child DOES have allergies. |
| List any allergies. Please include food and nonfood items. |
| A typical allergic reaction has the following symptoms (please describe). |
| Follow the below procedures if my child experiences an allergic reaction. |
| Medications and instructions, provided by the parent, to be used in the event of an emergency are: |
| <input type="checkbox"/> My child DOES NOT have dietary restrictions. <input type="checkbox"/> My child DOES have dietary restrictions. |
| List any dietary restrictions. |

MEDIA RELEASE

| | |
|-------------------|--------------------|
| Student Last Name | Student First Name |
|-------------------|--------------------|

Throughout the school year, students participate in art shows, classroom projects, singing performances, and school productions.

Occasionally and with the Director's approval, staff, parents, family, other participants or attendees, and local media cover these events by taking photographs or recording audio and/or video or other media formats (hereinafter "Media"). This Media may be used in or by, but not limited to, Concordia Church & School (Concordia), newspapers, television, websites, or other media production. This specifically includes Concordia's website and other school-related materials, including but not limited to, online, print, and/or any other formats, existing or created in the future, of marketing materials.

By signing below, you agree that you have been notified of the possibility that your child may be included in such Media and authorize the use of such Media. In addition, by signing below you further authorize the use of these materials indefinitely without compensation to you or your child. All negatives, positives, prints, digital reproductions, and video or audio recordings created by Concordia or its designees shall be the property of Concordia.

You can choose to have your child not participate in these photographed or videotaped events. Please be aware, however, that this release is not intended to provide any guarantee that such Media will not be taken and Concordia does not agree to assume any liability for such Media taken by persons or companies that are not acting on behalf of Concordia. In addition, Concordia has no control over such Media taken in the public square or viewable from the public square and offers no guarantee or policing effort in this regard.

Please initial one box below.

Initials

I, the Parent/Legal Guardian of the student named above, **give** permission for my child's name or Media to be used as outlined herein.

Initials

I, the Parent/Legal Guardian of the student named above, **do not give** permission for my child's name or Media to be used for school-related materials, the school's website, or other online or marketing materials. The student will be excused from participation in the events that Concordia intends to photograph or tape, including school productions. I specifically acknowledge that Concordia does not guarantee that Media will not be taken and have no control over the actions of others or activities or otherwise that operate in the public square or are viewable from the public square and assume the risk that such Media may be taken.

Parent/Legal Guardian Signature

| | | |
|----------------|-----------------|------|
| Sign Full Name | Print Full Name | Date |
|----------------|-----------------|------|