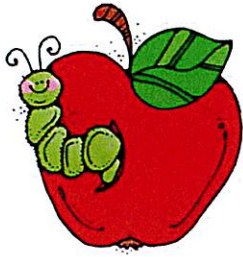


First Presbyterian Preschool



2025-2026 School Year

REGISTRATION

We are looking forward to a wonderful 2025 – 2026 school year!

Our first day of school for the Fall will be on

Tuesday, September 2.

We still have spots available for children from 2.5 to 5 year olds in all our sessions. Please check the requirements below to be sure you have everything you need to register. Thank you!

Registration Requirements for All Children

- ✓ **Registration Packet** completely filled out. Please be sure to include a **CURRENT PICTURE** of your child. (If you don't have one printed, you can email it to us.)
- ✓ **\$125.00 Fall Registration Fee** (Non-refundable). You can pay with Cash or Check. Please make checks payable to: First Presbyterian Preschool.
- ✓ **Up-To-Date and COMPLETE Immunization Record** needs to be turned in (we will make a copy for our files). The immunizations required are: 3 Polio Doses, 4 DTaP, 1 MMR (given on or after the first birthday), 1 HIB (given on or after the first birthday), 3 Hep B, and 1 Varicella.
- ✓ **Physical**: If you cannot have your child's Physical done by the time you turn in your packet, please call your pediatrician to schedule an appointment. Be sure to bring, mail, or email the Physical as soon as possible. The Physical Form can be found at the end of the Registration Packet.
- ✓ *** September Tuition** will be due on or before August 7, 2025. (Non-refundable).

Sincerely,
Misty Wren, Director

869 N. Euclid Ave., Upland, 91786 * 909-982-8616 * Website: www.fpc-upland.com

Email: preschooldir@fpc-upland.com * Instagram: [1stpresbyterianpreschool](https://www.instagram.com/1stpresbyterianpreschool)



First Presbyterian Church Preschool

869 N. Euclid Ave., Upland, CA 91786 909-982-8616
www.fpc-upland.com preschooldir@fpc-upland.com
Instagram: @1stpresbyterianpreschool

Office Use Only

Reg. Fee: _____ Tuition: _____
Cash No. _____
Immunizations _____
Physical _____
REMIND App _____

* Registration Packet 2025 - 2026 School Year *

Child's Name _____
Address _____
Mother's Name _____
Mother's Address _____
Place of Employment _____
Father's Name _____
Father's Address _____
Place of Employment _____

Birthdate _____
Name to be called in class _____
Home Phone _____
Mother's Cell _____
Mother's E-mail _____
Home Phone _____
Father's Cell _____
Father's E-mail _____

Please circle above who you would like to have as your child's PRIMARY CONTACT.

Child Lives With (circle all that apply) Father Mother Stepfather Stepmother Grandparent(s)

List ALLERGIES or HEALTH CONCERNS (asthma, milk intolerance, etc.) _____

Medication(s) for allergy (if any, i.e. Epi-Pen, Benadryl, etc.) _____

***How did you hear about our Preschool? _____

Check One Program

- ____ 2.5/young 3's Program – Will turn 3 years old after September of 2025 (Born after 9/2022)
- ____ 3 Year Old Program – Must be 3 years old by September of 2025 (Born by 9/2022)
- ____ PreKindergarten Program – Must be 4 years old by September of 2025 (Born by 9/2021)

Standard Tuition Rate per Month

<u>Morning Program 9:00 – 11:30 a.m.</u>	<u>Afternoon Program 12:30 – 3:00 p.m.</u>
2 Days (T/TH) \$241.00/month _____	3 Days (M/W/F) \$273.00/month _____
3 Days (M/W/F) \$273.00/month _____	<u>Full Day Program 9:00 – 3:00 p.m.</u>
5 Days (M-F) \$514.00/month _____	3 Days (M/W/F) \$546.00/month _____
	<u>ALL Programs : Full Day MWF and T-Th AM</u>
	ALL Days & Sessions \$787.00/month _____

Discounted Tuition Rate per Month (When paid ON or BEFORE the 7th)

2 Days (T/TH) \$221.00/month	3 Days (M/W/F) \$253.00/month	5 Days (M-F) \$474.00/month	Full Days (M/W/F) \$506.00/month	ALL Programs (All M/W/F & T-Th) \$727.00/month
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Please include a wallet-size picture of your child below.

Registration Fee \$125.00 - Due at time of registration / September's Tuition – Due by August 7th, 2025

REGISTRATION AND FIRST MONTH'S TUITION ARE NON - REFUNDABLE

By signing below I acknowledge that I have read and understand the registration requirements. I understand the financial obligation I am assuming for my child and agree to these arrangements. I understand that my child's enrollment at First Presbyterian Preschool shall be contingent upon the payment of all tuition due (enrollment may be terminated if tuition becomes past due); and that tuition is a yearly amount broken down into monthly payments, and thus not discounted for any holidays or absences.

Date _____ Parent/Guardian Signature _____

Office Use Only

Your Child Has Been Enrolled In: Teacher _____ Room# 103 104 105 106 107 109 110

Starting Date FALL 2025 _____ Days MWF MWF Full Day T/TH M thru F Time 9:00 to 11:30 12:30 to 3:00

Please see the reverse side to sign a permission form

Permission Form

At different times of the school year, we might take photos or videos of your child and other children in his/her class to share on our Instagram account, things such as a classroom activity, or a special event like an Easter Hunt. Names of students will NOT be published along with any pictures or videos.

Please check one of the following:

I grant permission for First Presbyterian Preschool to possibly use pictures of my child's face for their Instagram account.

I Do Not grant permission for First Presbyterian Preschool to possibly use pictures of my child's face for their Instagram account.

Child's First & Last Name _____

Date _____ Parent/Guardian Signature _____

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* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
----------------------------	-----------------------------------	---

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> 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
--	------

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

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

First Presbyterian Preschool _____ 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

()

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

Department of Social services Community care Licensing

ADDRESS

3737 Main Street suite 700

CITY

Riverside ca

ZIP CODE

92501

AREA CODE/TELEPHONE NUMBER

951 782-4200

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)

First Presbyterian Preschool

(PRINT THE ADDRESS OF THE FACILITY)

869 North Euclid Ave Upland, Ca 91786

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

Parent

(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: Department of Social Services Community Care Licensing

Licensing Office Address: 3737 Main Street Suite 700 Riverside Ca 92501

Licensing Office Telephone #: 951 782- 4200

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.

First Presbyterian Preschool

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

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is <http://cclid.ca.gov/contact.htm>.

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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
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.