Loomis Community Preschool
6414 Brace Road, Loomis, CA 95650
(916) 652-7842
License # 310-300416
loomispreschool.com

# Returning Student - Enrollment Checklist

We are so excited that your family will be returning to LCP! Please follow the steps listed below to complete your child's registration.

- [ ] Complete the online application at loomispreschool.com/forms
- [ ] Pay the $75 registration fee via Paypal or check

*Application & registration fee are required to hold your child's spot.*

- [ ] Print and fill-out the returning family packet: loomispreschool.com/forms. Turn in paperwork to the Admin/Membership box at school.
  - [ ] Membership Agreement
  - [ ] Emergency Information
  - [ ] Consent for Emergency Medical Treatment

You will receive a welcome letter and family job preference survey via e-mail in June.

Questions? Send an e-mail to lcpmembership1516@gmail.com

## Thank you!

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Loomis, Calif. 95650
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# MEMBERSHIP AGREEMENT

1. I agree to abide by the rules and procedures of the Loomis Community Preschool.

2. I agree to abide by the Health and Safety standards set by the school and the State of California.

3. I agree to attend the evening meetings.

4. I agree to participate in the classroom on the days assigned to me or arrange for a substitute to take my place.

5. I agree to share in the other work necessary to the school's operation including cleaning and maintaining the classroom and equipment (one workday per year and one set up or clean-up day per year) or pay a fine represented in the Handbook.

6. I agree to assist in any mandatory fundraising for the operation of the school and/or pay a fine.

7. I agree to make any tuition payments by the first of each month. (Tuition payments are considered delinquent after the tenth of the month, at which time there is a late charge. I will notify Treasurer if I need to be late.)

8. I understand that after 2 missed mandatory meetings, scheduled workdays, or any combination of those requirements, my case may be reviewed by the Membership Committee for possible membership termination.

9. I understand and will abide by the following termination policy, should I choose to withdraw my child from the school. A two-week written notice must be given to the teacher. All of my commitments are to be fulfilled during this two week period: this includes tuition, classroom work days, classroom jobs, and any fundraising event commitments that fall within the 2-week period. If a two-week written notice is not given, tuition for the following month is owed.

Parent's Signature_____

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 |
| 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

Loomis Community Preschool
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

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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 |
|---|---|
| (  ) | (  ) |