Trinity Presbyterian Preschool

Volunteer Release and Waiver of Liability Form

Required of each Parent / Guardian and all Co-Oping Adults

Please print.

Child(ren)'s Last Name: _____

Name ("The Volunteer"): _____

Relationship to student(s): _____

This Release and Waiver of Liability ("the Release") releases Trinity Presbyterian Preschool (TPP), a nonprofit corporation, and its directors, officers, employees, and agents.

I, _____ (the "Volunteer") desire to work as a volunteer for Trinity Presbyterian Preschool and engage in the activities related to being a volunteer. As Volunteer, I understand that the scope of my relationship with TPP is limited to a volunteer position and that no compensation is expected in return for services provided by me; that TPP will not provide any benefits traditionally associated with employment; and that I am responsible for my own insurance coverage in the event of personal injury or illness as a result of my services as volunteer to TPP.

1. **Waiver and Release**: I, the Volunteer, release and forever discharge and hold harmless TPP and its successors and assigns from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from the services I provide to TPP. I understand and acknowledge that this Release discharges TPP from any liability or claim that I may have against TPP with respect to bodily injury, personal injury, illness, death, or property damage that may result from the services I provide to TPP or occurring while I am providing volunteer services.

2. **Insurance**: Further I understand that TPP does not assume any responsibility for or obligation to provide me with financial or other assistance, including but not limited to medical, health, or disability benefits or insurance. I expressly waive any such claim for compensation or liability on the part of TPP beyond what may be offered freely by TPP in the event of injury or medical expenses incurred by me.

3. **Medical Treatment**: I hereby release and forever discharge TPP from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other medical services rendered in connection with an emergency during my tenure as a volunteer with TPP.

4. **Assumption of Risk**: I understand that the services I provide to TPP may include activities that may be hazardous to me. As a volunteer, I hereby expressly assume risk of injury or harm from these activities and Release TPP from all liability.

5. **Other**: As a volunteer, I expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the State of California and that this Release shall be governed by and interpreted in accordance with the laws of the State of California. I agree that in the event that any clause or provision of this Release is deemed invalid, the enforceability of the remaining provisions of this Release shall not be affected.

By signing below, I express my understanding and intent to enter into this Release and Waiver of Liability willingly and voluntarily.

_____ _____

Signature Date

TRINITY PRESBYTERIAN PRESCHOOL

CO-OP ADULT PARTICIPATION REQUIREMENTS

In compliance with operational guidance, Licensing and state law, **ALL** co-oping adults are required to have on file:

1. **Volunteer Release Form** (available on Admissions page)
   This form must be on file for all co-oping adults.

2. **Pertussis** (Whooping Cough) vaccination
   Commonly administered with tetanus via a combo vaccine called Tdap

3. **Measles** vaccination
   Most commonly administered via the combo vaccine MMR but may have been administered independently. For our co-oping grandparents, please be advised that those born prior to 1957 are exempt from the Measles vaccine requirement.

4. **Negative TB (Tuberculosis) Test**
   The results of a skin or blood test may be submitted. In the event the result is positive, a negative chest x-ray is necessary to meet the requirement. Results must be obtained within the 12 months prior to the start of the school year. ***A new TB test is required for each newly enrolled child.***

5. **Influenza** Vaccination or Declination Form
   Must be submitted annually. The vaccination must be obtained between August 1 and December 1.

Pertussis, Measles, and TB results need to be submitted once when a child starts at Trinity. The Influenza requirement is annual. If not already on file, Pertussis, Measles and TB requirements must be met by August 1 and returned with your enrollment paperwork. Proof of the Influenza vaccination or the Declination Form (attached) must be returned to the school office no later than December 1.

Compliance with the above medical requirements can be secured by submitting **hardcopies only** of:

1. An immunization record documenting Pertussis and Measles vaccines**; **or**
   A signed letter from a licensed physician documenting your immunity to Pertussis and Measles; **or**
   A signed letter from a licensed physician declaring that immunization is unsafe for you due to a physical condition or medical circumstance.

2. A copy of your TB test results (test must be within 12 months of the start of the school year). **Required with each new student.**

3. A copy of your Influenza vaccination obtained between August 1 and December 1 of the current school year, or submission of the Influenza Vaccination Declination Form.

** *Proof of immunity is often obtained during pregnancy. Please check with your Physician / OB.*

Please proceed to cover form on next page.

TRINITY PRESBYTERIAN PRESCHOOL

CO-OP ADULT PARTICIPATION COVER SHEET

1. Please complete one form per co-oping adult.
2. Attach all required documentation. Incomplete sets, or emailed results will be returned.

Date: _____

Child(ren)'s Last Name: _____

Class(es): __ **TWOs** __ **TTH/TTH Flex** __ **MWF3s** __ **MWF Pre-K** __ **PM Pre-K**

Name: _____ **Relationship:** _____
Please print.

Volunteer Release and Waiver of Liability:

___ I have submitted the Volunteer Release form with my child's enrollment paperwork.

or

___ I am a non-parent/ guardian family member and have attached the Volunteer form.

Immunization Status

___ **Returning Student:** My child attended last year and I have Pertussis, Measles and TB records on file.

or

___ **New Student (Sibling):** I co-oped last year and my records are on file. **I have attached a current TB test.**

or

___ **New Student:** I have attached proof of Pertussis and Measles** immunity and a negative TB test result.

___ ** I was born prior to 1957 and am exempt from the Measles vaccine requirement.

___ **Medical Exemption:** I have attached a letter from my physician detailing a medical exemption.

Flu Vaccination

___ I am intending to obtain an Influenza vaccine between August 1 and December 1 and will forward the results by December 2.

or

___ I have attached the Influenza Vaccination Declination Form.

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.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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 (MM/DD/YY)

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	HOME TELEPHONE	CELL TELEPHONE

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	BUSINESS TELEPHONE

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	HOME TELEPHONE	CELL TELEPHONE

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	BUSINESS 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 (MM/DD/YY)

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 Trinity Presbyterian 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:

PLEASE INDICATE IF CHILD HAS FOOD ALLERGIES OR ASTHMA. ___ ALLERGY ACTION PLAN HAS BEEN PROVIDED TO TPP

PLEASE PROVIDE SIBLING INFORMATION BELOW, IF APPLICABLE:

NAME	GRADE	SCHOOL	SCHOOL PHONE
NAME	GRADE	SCHOOL	SCHOOL PHONE
NAME	GRADE	SCHOOL	SCHOOL PHONE

DATE (M/DD/YY)

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER 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?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST _____
	LUNCH	LUNCH_____
	DINNER	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'S 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'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, 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'S SIGNATURE	DATE

Trinity Presbyterian Preschool
Photo Release Form

LAST NAME: _____

Oldest Child's Class:

___ AM TWOs **___ TTH/TTH Flex** **___ MWF3s** **___ MWF Pre-K** **___ PM Pre-K**

I hereby authorize Trinity Presbyterian Preschool ("TPP") to publish photographs taken of me and/or the undersigned minor children, for use in the Trinity Presbyterian Preschool website and/or printed publications.

I release Trinity Presbyterian Preschool from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize Trinity Presbyterian Preschool to use said photographs. Photos will consist of child actively learning and/or playing at TPP or TPP related events (e.g. Elkus Ranch, Ice Cream Social, etc.), and will not include names.

Permission I acknowledge that since participation in publications and websites produced by Trinity Presbyterian Preschool is voluntary, neither the minor children nor I will receive financial compensation.

I further agree that participation in any publication and website produced by Trinity Presbyterian Preschool confers no rights of ownership whatsoever. I release Trinity Presbyterian Preschool, its director, board members and employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

___ I do not authorize use of photos for the below named Trinity student(s).

PLEASE LIST ALL CHILDREN CURRENTLY ENROLLED AT TRINITY:

Name	**Class**
_____	_____
_____	_____
_____	_____

Parent / Guardian. Please Print:

Name: _____

_____ _____
Signature Date

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

PENINSULA CHILD CARE DISTRICT OFFICE

ADDRESS

801 Traeger Avenue, Suite 100, MS 29-24

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Bruno, CA	94066	650.266.8843

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)
Trinity Presbyterian Preschool	1106 Alameda San Carlos, CA 94070

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	DATE (MM/DD/YY)

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: Peninsula Regional Office - Child Care

   Licensing Office Address: 801 Traeger Ave., Suite 100, San Bruno, CA 94066

   Licensing Office Telephone #: 650-266-8843

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

Lie 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.

Trinity 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

TRINITY PRESBYTERIAN PRESCHOOL

FAMILY PREFERENCES

We will make every effort to accommodate requests. In the event a conflict arises, it is your responsibility to arrange a swap with another Trinity parent. **Your requested preference days will not be considered unless <u>all</u> paperwork is complete and turned in by August 1.**

CHILD(REN)'S LAST NAME: _____

CLASS: __ TWOs __ TTH / FLEX3s __ MWF3s __ MWF Pre-K __ PM Pre-K

CO-OP PLAN (Threes & Pre-K only): ___ 1-Day ___ 2-Day

IF PREGNANT, please indicate your due date: _____. We offer a six-week Maternity Leave.[1]

___ I do not need a leave; I have family members who will co-op for me.

CO-OP WORK DAYS

Any adult family member may co-op. Adults co-oping two or more times per year are required to comply with the Adult Co-Op Medical Requirements (see form for details). **Please list only those family members with complete medical records attached or on file.**

Primary Co-Op Adult Name: _____ Relation to child(ren): _____

Co-Op Adult Name: _____ Relation to child(ren): _____

Co-Op Adult Name: _____ Relation to child(ren): _____

Please note: Every attempt is made to honor the 1-day or 2-day co-op preference per month for our Threes and Pre-K families. According to the actual number of school days per month, families may be scheduled for more, or fewer days per month, but never more than nine or eighteen total days during the school year.

□ **TWOS** I prefer to work on: __ Tuesday __ Thursday __ Either

□ **TTH3s / TTH Flex 3s** I prefer to work on: __ Tuesday __ Thursday __ Either

__ Flex Day: __ M __ W __ F

Flex Families may co-op on their Flex day in addition to Tues. and/or Thurs.

□ **MWF3s & MWF Pre-K** I can work on any of these days: __ Monday __ Wednesday __ Friday

I **CANNOT** work on this day: __ Monday __ Wednesday __ Friday

□ **PM Pre-K** I can work on any of these days: __ Tuesday __ Wednesday __ Thursday __ Friday

I **CANNOT** work on this day: __ Tuesday __ Wednesday __ Thursday __ Friday

- Continued on next page –

[1] MATERNITY LEAVE Mothers may take six calendar weeks maternity leave from co-oping (holiday weeks are included in the leave time). Co-oping parents may bring young infants in front or back packs, car seats, etc., until they are mobile.

MAINTENANCE DAYS

We understand the busy lives of our families sometimes warrant the need for flexibility. Maintenance Days are not required but may be completed to earn a deposit refund. Maintenance Days are held on Saturdays from 8:00am – 11:00am. **Please review the options below and indicate a preference for each parent:**

_____ **Opt Out**
I/we prefer to opt out. I/we understand the $125 Maintenance Fee(s) will be applied toward the cost of hired personnel.

_____ _____
Parent / Guardian Name **Signature**

_____ _____
Parent / Guardian Name **Signature**

_____ **Complete a Maintenance Day**
I/we will commit to completing a Maintenance Day. I understand upon completion of a workday, my/our $125 Maintenance Fee will be refunded. The schedule will be distributed in September.

Parent / Guardian Name: _____
Please print.

Email: _____

Parent / Guardian Name: _____
Please print.

Email: _____

TRINITY PRESBYTERIAN PRESCHOOL

GETTING TO KNOW YOUR CHILD

We look forward to working with you and your child this year. Please help us to get to know your child by answering the following questions. **Please print.**

Child's Class ___ Twos ___ TTH / FLEX3s ___ MWF3s ___ MWF Pre-K ___ PM Pre-K

Child's Name: _____

Birthdate (mm/dd/yy): _____ Nickname: _____

Your Name: _____

Please tell us a little about your family, especially siblings (names and ages), extended family (if they are actively involved in your child's life) and pets:

What languages are spoken at home?

Has your child had prior school experience or experience with caregivers that were not family? If yes, please describe any special likes or dislikes she/he had about school, daycare, etc.

Describe some of the qualities you especially appreciate about your child.

What are your child's favorite activities and interests?

What are your child's strengths?

Does your child have any unusual or strong fears?

How would you describe your child's energy level?

Do you have any special concerns about your child?
Hearing and/or Vision? Speech and Language Development? Ability to Move (Gross Motor)? Overall Development?

Does your child have any special medical history?

Has your child received / is your child receiving, outside services (Speech, OT, ABA, etc.)? Please include timeframe.

Has your child begun potty training, and if so, what stage is he/she in?

Is there anything else you think we should know about you or your child?

Are there any special talents that you have that you would like to share with our children in class? (i.e. playing a musical instrument, singing, gardening, art, another language, something related to your profession)

Additional Comments: