



BRIGHT BEGINNINGS PRESCHOOL

2011-12 Registration Packet

Enclosed you will find the necessary papers to fully register your child at Bright Beginnings for the 2011-12 school year.

If you have any further questions, please contact Allison Lane in the school office
360-882-3496.

Registration Check List

- Non-Refundable registration fee.
- Completed Registration Forms. (Pages 3, 5 thru 8)
- Signed and initialed Payment Contract (page 4)
- Completed Certificate of immunization
- Both sides of forms (where applicable) have been completed.
- Copy of valid Birth Certificate
- Please return your packet in this large manila envelope
- September Tuition is due by the 15th of August

Thank You!

Program Basics

Preschool

3-Year-Old Classes: Class size: 16 students, class ratios 8:1. Students must be three years old by September 1, 2011, and toilet trained.

Pre-K

4-Year-Old Classes: Class size: 18 students, class ratios 9:1. Students must be four years old by September 1, 2011.

4 / 5 Year Old Classes: Class size: 18 students, class ratios 9:1. Students must be five years old by December 31, 2011.

All of our 3 thru 5 years old classes provide children with time to explore as they learn. Children will be engaging in activities that will support their development through a hands-on learning approach.

Our curriculum includes:

Bible Stories and Memorization
Art
Physical Movement
Science/Heath
Writing/Penmanship
Story Times
Social Studies

Reading Readiness
Sensory Play
Music
Arithmetic
Dramatic Play
Manners/Personal Care
Cooking

- ★ All classes will be staffed according to the above student teacher ratios with a Lead Teacher and a Co-teacher.
- ★ Child should wear clothing appropriate for preschool activities such as outdoor play, sitting on the floor, and painting.

Bright Beginnings 2011-12 Registration

| | | | |
|---------------------------|--------------|--|--------------------------|
| <i>Child's Last Name,</i> | <i>First</i> | <i>Boy or Girl?</i> <input type="checkbox"/> <input type="checkbox"/> | <i>Birth date</i> / / |
| Parent's Name (s) | | Home phone () | Cell Phone () |
| Home E-mail address | | | |
| Street Address | | City | Zip code |

Class Information: September – June

| <i>Class Sessions September - June</i> | <i>Age By Sept. 1 2011</i> | <i>Class Time</i> | <i>Bright Beginnings Non-Refundable Registration Fee</i> | <i>Monthly Tuition Payments (10 months)</i> |
|--|------------------------------------|-------------------|--|---|
| <i>Preschool Classes:</i> | | | | |
| ___ 1. M-T (2 mornings) | 3 | 9:00 –11:40 a.m. | \$85 | \$109 |
| ___ 2. W-Th-F (3 mornings) | 3 | 9:00 -11:40 a.m. | \$85 | \$160 |
| <i>Pre-Kindergarten Classes:</i> | | | | |
| ___ 3. M-T (2 mornings) | 4 | 9:00 -11:40 a.m. | \$85 | \$109 |
| ___ 4. W-Th-F (3 mornings) | 4 | 9:00 -11:40 a.m. | \$85 | \$160 |
| ___ 5. T-W-TH-F (4 mornings) | 4.5 | 9:00 -11:50 p.m. | \$85 | \$210 |

Bright Beginnings reserves the right to cancel any class if there is insufficient registration.
It also reserves the right to balance class ratios.

Please make checks payable to: Bright Beginnings



Payment Contract

PLAN A: In Full

- \$85 nonrefundable registration fee (per child) to Bright Beginnings Preschool due at the time of registration. This fee will hold the student's seat in class until August 15th.
- One (1) payment of \$_____ to Bright Beginnings Preschool due by August 15th.
- In the event that the student withdraws from the preschool the \$85 registration fee and the next month tuition (if request is made after the 15th of the month) of \$_____ is retained by the preschool. The remainder will be refunded within 30 days of written request.
- Payments not made by August 15th will result in your child's seat being given to a child on the waiting list.
- Returned check fees charged by the bank will be added to your account.
- Students must be picked up within 10 minutes of class ending. The cost to have staff remain past their time is \$8 per 15 minutes, changed in 15 minute increments. This charge will be deducted from your payment and additional payments may be due at the end of the school year.

PLAN B: Payment Plan

- \$85 nonrefundable registration fee (per child) to Bright Beginnings Preschool due at the time of registration. This fee will hold the student's seat in class until August 15th.
- Ten (10) monthly payments of \$_____ to Bright Beginnings Preschool due by the 15th of the preceding month.
- First payments not made by August 15th will result in your child's seat being given to a child on the waiting list.
- In the event that the student withdraws from the preschool the \$85 registration fee is retained by the preschool and the next month tuition (if request is made after the 15th of the month) of \$_____ is charged to the parent.
- Late payments, made between the 20th and 30th of the next month, will have a 10% late fee added.
- Payments not made by the 30th of the month will result in the student not being allowed to return to school. Payments made after this time will have a 10% late fee added.
- Returned check fees charged by the bank will be added to your account.
- Students must be picked up within 10 minutes of class ending. The cost to have staff remain past their time is \$8 per 15 minutes, changed in 15 minute increments. This charge will be deducted from your payment and additional payments may be due at the end of the school year.

I agree to pay monthly tuition by the 15th of each preceding month and understand my child(ren) may be excluded from school if my account falls behind. _____

Student Information

| | | | |
|-------------------|-----|-----|--------------|
| Child's Full Name | | | |
| Date of Birth | Age | Sex | Today's Date |

Parent/Guardian Information

| | | | |
|---------------------|--|-------|------------|
| Father's Name | | Phone | |
| Address | | Zip | Cell |
| Place of Employment | | | Work Phone |

| | | | |
|---------------------|--|-------|------------|
| Mother's Name | | Phone | |
| Address | | Zip | Cell |
| Place of Employment | | | Work phone |

Sibling Information

| | | |
|------|-----|--------|
| Name | Age | School |
| Name | Age | School |
| Name | Age | School |
| Name | Age | School |

Additional Information

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

Dismissal Authorization

| | | |
|---|--------------|---------------|
| The following are authorized to remove _____ from school: | | |
| Name | Relationship | Daytime phone |
| Name | Relationship | Daytime phone |
| Name | Relationship | Daytime phone |

Emergency Contacts

(Parents will be the first contacted. Please list order in which friends or relatives should be contacted if we are unable to make contact with a parent.)

| | | |
|------|--------------|---------------|
| Name | Relationship | Daytime phone |
| Name | Relationship | Daytime phone |
| Name | Relationship | Daytime phone |
| Name | Relationship | Daytime phone |

General Information

(Please share any information that will help us to know your child better)

| | |
|--|--|
| Type of previous group or preschool experience? | Where? |
| Other languages spoken in your home: | Are there any nicknames the student likes? |
| Fears your child may have (dog, sirens, etc) | |
| Any unusual experiences your child may have had (moving, hospital stay, loss of someone dear)? | |
| Additional comments or concerns: | |
| Food Allergies: | |

Medical Agreement

| | |
|--------------------|-------|
| Doctor preferred | Phone |
| Hospital preferred | Phone |
| Insurance Company | Phone |
| Policy Number | |

| |
|----------------------------|
| Please list all Allergies: |
| |
| |
| Medical Concerns: |
| |
| |
| Physical Limitations: |
| |
| |

I (We) the undersigned, parent or legal guardian of _____, a minor, do hereby authorize and consent for Bright Beginnings 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.

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

Signature _____ Date _____

Signature _____ Date _____

Release of Information Agreement

Bright Beginnings will not post photos with any current Bright Beginnings students on the Bright Beginnings web site or any other web site.

Photos of children are used in the classrooms, to share with parents and staff, and for use in promotional and information materials (such as the Bright Beginnings brochure or information to the Vancouver Church).

Photos of former students, without any identifying information and photo tags to indicate photos of former students, may be used on the Bright Beginnings web site or other electronic media.

I/We _____ hereby grant permission for Bright Beginnings to take photos of my/our child _____ and use his/her photo or his/her quotes in the classrooms, to share with parents, and for use in promotional and information materials.

(Please initial by your response)

Yes _____ No _____

Signature _____ Date _____

Signature _____ Date _____

Bright Beginnings is a ministry of the Vancouver Church of Christ and is located in the church building. **The Vancouver Church would like to include you in mailings and/or e-mail information about events and activities.**

- Yes, the Vancouver Church may mail me information
- Yes, the Vancouver Church may send e-mails
- No, I'd rather not receive any information from the Vancouver Church

Signature _____ Date _____



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

| | |
|---|-------------|
| Office Use Only: | |
| Reviewed by: _____ | Date: _____ |
| Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

| | | | | | |
|--|--------------------------|------------------------------|--------------------------------------|---|--|
| Child's Last Name: _____ | First Name: _____ | Middle Initial: _____ | Birthdate (mm/dd/yyyy): _____ | Sex: _____ | I certify that the information provided on this form is correct and verifiable. |
| Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only | | | | Parent/Guardian Name (please print): _____ | |

| Vaccine | Dose | Date | | |
|---|------|-------|-----|------|
| | | Month | Day | Year |
| ◆ Hepatitis B (Hep B) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| or Hep B - 2 dose alternate schedule for teens | | | | |
| | 1 | | | |
| | 2 | | | |
| Rotavirus (RV1, RV5) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| ◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| | 5 | | | |
| ◆ Tetanus, Diphtheria, Pertussis (Tdap, Td) | | | | |
| | 1 | | | |
| | 2 | | | |
| ● Haemophilus influenzae type b (Hib) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| ● Pneumococcal (PCV, PPSV) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |

| Vaccine | Dose | Date | | | | | |
|--|------|------------|-----|--------------------------|--|------------|--|
| | | Month | Day | Year | | | |
| ◆ Polio (IPV, OPV) | | | | | | | |
| | 1 | | | | | | |
| | 2 | | | | | | |
| | 3 | | | | | | |
| | 4 | | | | | | |
| Influenza (flu, most recent) | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| ◆ Measles, Mumps, Rubella (MMR) | | | | | | | |
| | 1 | | | | | | |
| | 2 | | | | | | |
| ◆ Varicella (chickenpox) or verify disease 1-4 ▶ | | | | | | | |
| | 1 | | | | | | |
| | 2 | | | | | | |
| Hepatitis A (Hep A) | | | | | | | |
| | 1 | | | | | | |
| | 2 | | | | | | |
| Meningococcal (MCV, MPSV) | | | | | | | |
| | 1 | | | | | | |
| Human Papillomavirus (HPV) | | | | | | | |
| | 1 | | | | | | |
| | 2 | | | | | | |
| | 3 | | | | | | |
| Office Use Only: Immunization information updated and verified with parent/guardian permission: | | | | | | | |
| Printed Staff Name _____ | | Date _____ | | Printed Staff Name _____ | | Date _____ | |
| Printed Staff Name _____ | | Date _____ | | Printed Staff Name _____ | | Date _____ | |

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

| | | |
|--------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rubella | _____ |
| <input type="checkbox"/> Hib | <input type="checkbox"/> Tetanus | _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Varicella | _____ |

Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

| Vaccine | Dose | Date | | |
|---|----------|-------|-----|------|
| | | Month | Day | Year |
| ◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT) | | | | |
| DTaP | 1 | 01 | 12 | 2011 |
| DTaP | 2 | 03 | 20 | 2011 |
| DTaP | 3 | 06 | 01 | 2011 |

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

| Vaccine Trade Names in alphabetical order | | | | | | | | | |
|---|-------------|-----------|------------|------------------|--------------------|-------------------|----------------------|-----------------|---------------|
| ActHIB | Hib | Engerix-B | Hep B | Ipol | IPV | Pentavalente | DTaP + Hep B + Hib | TriHIBit | DTaP + Hib |
| Adacel | Tdap | Fluarix | Flu (TIV) | Infanrix | DTaP | Pneumovax | PPSV or PPV23 | Tripedia | DTaP |
| Afluria | Flu (TIV) | FluLaval | Flu (TIV) | Kinrix (Knrx) | DTaP + IPV | Prevnar | PCV or PCV7 or PCV13 | Twinrix (Twnrx) | Hep A + Hep B |
| Boostrix | Tdap | FluMist | Flu (LAIV) | Menaetra | MCV or MCV4 | ProQuad (PrQd) | MMR + Varicella | Vaqa | Hep A |
| Cervarix | HPV2 | Fluvirin | Flu (TIV) | Menomune | MPSV or MPSV4 | Quadracel (Qdrel) | DTaP + IPV | Varivax | Varicella |
| Comvax (Cmvx) | Hep B + Hib | Fluzone | Flu (TIV) | Pediarix (Pdrx) | DTaP + Hep B + IPV | Recombivax HB | Hep B | | |
| Daptacel | DTaP | Gardasil | HPV4 | PedvaxHIB | Hib | Rotarix | Rotavirus (RV1) | | |
| Decavac | Td | Havrix | Hep A | Pentacel (Pntcl) | DTaP + Hib + IPV | RotaTeq | Rotavirus (RV5) | | |

| Vaccine Abbreviations in alphabetical order | | | | | | | |
|---|--|-------------|--------------------------------------|----------------------|--|-------------------|--|
| DT | Diphtheria, Tetanus | Hep A (HAV) | Hepatitis A | MPSV or MPSV4 | Meningococcal Polysaccharide Vaccine | Rota (RV1 or RV5) | Rotavirus |
| DTaP | Diphtheria, Tetanus, acellular Pertussis | Hep B (HBV) | Hepatitis B | MMR / MMRV | Measles, Mumps, Rubella / with Varicella | Td | Tetanus, Diphtheria |
| DTP | Diphtheria, Tetanus, Pertussis | Hib | <i>Haemophilus influenzae</i> type b | OPV | Oral Poliovirus Vaccine | Tdap | Tetanus, Diphtheria, acellular Pertussis |
| Flu (TIV or LAIV) | Influenza | HPV | Human Papillomavirus | PCV or PCV7 or PCV13 | Pneumococcal Conjugate Vaccine | TIG | Tetanus immune globulin |
| HBIG | Hepatitis B Immune Globulin | IPV | Inactivated Poliovirus Vaccine | PPSV or PPV23 | Pneumococcal Polysaccharide Vaccine | VAR or VZV | Varicella |

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

DOH 348-013 January 2010

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