Palisades Christian Learning Center Registration

Phone: 509-327-8387 Email: jarmilav@palisadeschristian.org FAX: 509-324-8904

Applying for: ☐ **Toddler (12-36 M)** ☐ **Preschool (30 M-4 1/2)** ☐ **Pre-K (ages 5-6)**

Application Date _____ Start Date _____ Withdrew _____

Student's Full Name _____
Last First Middle

Address _____ City _____

State _____ Zip Code _____

Student Home Phone _____ Email address _____

Does PCLC have permission to share this address with classmates for mailing birthday invitations?

☐ Yes ☐ No

Age _____ Birth date _____ Nickname: _____

Gender: ☐ Male ☐ Female

Student resides with: ☐ Mother ☐ Father ☐ Stepfather ☐ Stepmother

☐ Other: _____ ☐ Parent active in Military?

Mother's Information

Full Name _____ Home Phone _____
Last First M

Current Address _____ City _____

State _____ Zip Code _____ Cell Phone _____ Email Address _____

Occupation _____ Work Phone _____

Father's Information

Full Name _____ Cell: Phone _____
Last First Middle

Current Address if different: _____ City _____

State _____ Zip Code _____ Email Address: _____

Occupation _____ Work Phone: _____

Palisades Christian Learning Center

Full Time/ Part Time Agreement

Child's Name: _____ Classroom _____

Date of Enrollment: _____ Date of Withdrawal: _____

Age: _____ Potty Trained/ Not Potty Trained: _____

My child will be attending: ☐ Full Time Part Time: ☐ AM ☐ PM

Number of Half Days per Week: _____ Number of Full Days per Week: _____

Days:
- ☐ Monday Arrival Time: _____ Departure Time: _____
- ☐ Tuesday Arrival Time: _____ Departure Time: _____
- ☐ Wednesday Arrival Time: _____ Departure Time: _____
- ☐ Thursday Arrival Time: _____ Departure Time: _____
- ☐ Friday Arrival Time: _____ Departure Time: _____

Registration Fee: _____ Monthly Tuition: _____

Parent Signature: _____ Date: _____

An annual registration fee of $100.00 per child is required for enrollment. The registration fee is renewable each year. The fee covers consumable materials and learning supplies. Each family will still need to supply a lunch, 2 snacks, diapers, wipes and bedding if required (see Handbook).

Payments are due by the 5th of the month. Payments are to be made prior to service. A $25 late fee is applied for payments that are past due by 10 days and may result in termination of child care. Parents who pick up their children after 5:30pm will be charged a late fee of $5 per 5 minutes. (See Handbook)

Due upon enrollment

I hereby acknowledge that I have discussed, read and understand the Palisades Christian Learning Center Policies and Parent Handbook, and I agree to follow the procedures.

- I understand that if at any time I have questions, concerns or comments, I may openly discuss them with the Palisades Christian Learning Center Providers for immediate action, if at all possible.
- I have completed all the paperwork including the CIS form and have submitted them.
- I read and understand Emergency/Disaster Plan provide by PCLC
- I understand that my child may have information in his/her cubby and/or drawer. It is important to check it daily. PCLC will send important messages through the Brightwheel childcare app, email, phone calls. I understand I need to use the app to sign in/out my child every day and to communicate with my child's teacher.

Parent/ Guardian Signature _____ Date _____

AUTHORIZATION PICK UP FORM

A. The following people HAVE permission to pick-up the child named below from Palisades Christian Learning Center. It is the parent's responsibility to notify me in writing of any changes.

Child's Name	DOB	Age	Sex

1. Name: _____ Relation: _____
   Phone: _____ EMAIL: _____

2. Name: _____ Relation: _____
   Phone: _____ EMAIL: _____

3. Name: _____ Relation: _____
   Phone: _____ EMAIL: _____

4. Name: _____ Relation: _____
   Phone: _____ EMAIL: _____

B. The following people **MAY NOT** pick-up my child(ren) from Palisades Christian Learning Center

1. Name: _____ Relation: _____ Phone: _____
2. Name: _____ Relation: _____ Phone: _____

Note: Any person unfamiliar to me will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN permission from the parent.

This form is legally binding, so by signing it, you agree that all of the information provided herein is correct. False Information will result in termination of contract, and you will forfeit your childcare retainer.

Father/Guardian's Signature Date	CELL: WORK:
Mother/Guardian's Signature Date	CELL: WORK:

Medication Authorization Form

This for is needed for any medication a child will need to take or have applied in our care ☐ **Sunscreen** ☐ **Diaper Cream** ☐ **Other**

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Start Date:	Stop Date:
Times to be given:	Amount to be given:
Possible Side Effects:	Oral Topical Other
Above information consistent with label?	Requires Refrigeration: yes no
Special Instructions:	

/Guardian Signature Date

_____

Daytime Phone Number

_____ _____

Physician Signature (if needed) *Date*

_____

Physician Phone Number

ABOUT MY CHILD

To help us get to know your child and your family, please answer the following questions.

1. Has your child ever been in childcare before? YES NO
2. Does your child speak more than one language? What is the primary home language?

   _____

3. Are there some cultural events that are special to your family and that you would be willing to share with your child's class? Would you please share?

   _____

   _____

4. Where do you see your child's development?

   _____

   _____

   _____

   Is it where you would expect it? Behind? Advanced? Do you have any concerns?

   _____

5. How does your child interact socially with others? Please share examples?

   _____

   _____

6. Are there pets and/or other siblings in the family? Anyone else that lives with you? Please share their names and ages of siblings. Send a family picture for your child's teacher and classmates. We want to include them too.

   _____

   _____

7. How does your child learn best? What is their learning style?

   _____

   _____

Other Medical Information

Does your child have any special needs? Have an IEP? Please share with your teacher.

Has your child ever been tested for...? Please Circle

Hearing	YES	NO	Date: _____
Speech	YES	NO	Date: _____
Vision	YES	NO	Date: _____
Other	YES	NO	Date: _____

My Child has an Individual Health Plan (specific medical needs) which is as follows: (Please attach documentation from physician and/or intervention specialist)

PHOTO RELEASE

Throughout the year, photographs and video of the children are taken during activities and events. These photographs and recordings are used for in program use (bulletin boards, newsletters, yearbook, in-class projects, etc.) and, with permission, on our program's Facebook page and website. We also use a childcare app called Brightwheel to communicate with our parent's/ guardians and share pictures of your child's learning environment.

Regarding in-house use (check one box):

☐ I give my permission for images and video to be used by the program for in-house activities (bulletin boards, yearbook, newsletters, in-class projects, holiday program etc.)

☐ I do NOT give my permission for in-house use.

Regarding online use (check one box):

☐ I give my permission for images and video to be used by the program on their Facebook page and/or the website.

☐ No, I do NOT give my permission for Facebook and Website use.

Regarding Childcare App Brightwheel (check 2):

_____ I give permission for Palisades Christian Learning Center to send pictures of my child through Brightwheel.

_____ I do not give permission for Palisades Christian Learning Center to send pictures of my child through Brightwheel.

_____ I give permission for Palisades Christian Learning Center to include my child in group photos that will be sent to other parents from PCLC through Brightwheel.

_____ I do not give permission for Palisades Christian Learning Center (PCLC) to include my child in group photos that will be sent to other parents from PCLC through Brightwheel.

I understand that I have the right to request the removal of photos from the Facebook page or the website or childcare app at any time. I understand that I cannot download pictures that contains other students to share them with others and/or online. By signing below, I acknowledge my understanding of the above and grant my permission for the use as specified above.

_____

(please print child's name)

_____

(please print parent/legal guardian's name)

_____ _____

Signature of parent/legal guardian Date

School Activities Permissions

Field Trips

On occasion, children will be taken for supervised walks on the school property to enjoy the larger spaces and to learn about God's creation in our natural setting. Please sign to give your permission for this activity. Contact staff with any concerns.

For trips off our campus, parents will receive specific information.

Parent signature;_____ Date:_____

Water play activities:

We give children in our program sensory activities and water is a fun one to use. We will not be using large containers and the activity will be supervised. Examples of water play are washing toy dishes, pouring water from small and big containers, measuring and pouring, etc. Please sign to give your permission for this activity. Contact staff with any concerns.

Parent signature: _____Date:_____

Exposure to animals:

We like to give children opportunities to learn about animals and how to care for pets. When we invite guests, you will be notified in advance. Currently there are no pets on the premises however we will inform you if/when a classroom gets one. See our Health Policies for the details. We will always practice good hygiene and hand washing after being around pets. Please make sure to let us know about allergies. Please sign so we know you have read and understand.

Parent signature: _____ Date: _____

We are always glad to hear from you any suggestions or concerns you may have about our program. We like to include outdoor learning activities as the weather permits. Make sure your child has appropriate outdoor wear. We follow CDC guidelines.

CONSENT TO TREATMENT
PALISADES CHRISTIAN LEARNING CENTER
2022-2023 SCHOOL YEAR
DO NOT LEAVE ANY LINE BLANK

Student's Name _____
Last First Middle

Date of Birth: _____ Allergies/Reactions: _____
If child has allergies, please provide documentation and Action Plan from provider.

Mother's Name: _____ Cell # _____ Work# _____

Father's Name: _____ Cell # _____ Work# _____

Extra Emergency Contacts:

Name and phone # _____

Name and phone # _____

Medication taken on a regular basis: _____

Child's Illnesses or Past Surgeries: _____

Emergency Hospital _____ 2nd Choice _____

Immunizations up to date: ___Yes ___No Exempt? _____

Physician's Name: _____ Office Phone: _____

Date of Child's Last exam: _____

Dentist's Name: _____ Office Phone: _____

Date of Child's Last exam: _____

(Do not leave blank. Please write N/A if you have not found a dentist or physician at this time and give us the information as soon as it is available)

Palisades Christian Learning Center will provide basic first aid for minor injuries and illnesses. However, we cannot dispense medication of any kind, unless the office receives permission from the student's physician. Forms are available at the Learning Center office and need to be completed by the parents and the physician.

In case of accident or serious illness, the school will make every attempt to contact the student's parents or the emergency contact listed above.

If I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or EMT when deemed necessary or advisable by the physician or EMT to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid care to an emergency center for treatment.

Signature _____ Date _____

Emergency Plan *Child/Parent Information*

Complete one form for each child. Keep a copy of this information with your emergency kit(s).

Child's Information	
Child's Full Name	
Date of Birth	
Address	
Current medications	
Medical conditions/allergies	
Special needs or instructions	
Physician name / phone	
Parent / Guardian Information	
Full Name	
Relationship to Child	
Address	
Phone Number(s)	
Email Address(es)	
Place of Employment	
Parent / Guardian Information	
Full Name	
Relationship to Child	
Address	
Phone Number(s)	
Email Address(es)	
Place of Employment	

Additional Emergency Contacts: (include those who have permission to pick up the child and an out of area contact in case of a disaster). Children will only be released to contacts listed on the child's form who have proper identification.

Emergency Contacts name and phone number:

1. _____

2. _____

How will parents/guardians be contacted and reunite with children after the emergency:

Through phone or childcare app.

and/or calling parents phone

Certificate of Immunization Status (CIS)

Reviewed by: Date:
Signed COE on File? ☐ Yes ☐ No

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

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ Parent/Guardian Signature Date	X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date

▲Required for School • Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
•▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
•▲ DT or Td (Tetanus, Diphtheria)						
•▲ Hepatitis B						
• Hib (*Haemophilus influenzae type b*)						
•▲ IPV (Polio) (any combination of IPV/OPV)						
•▲ OPV (Polio)						
•▲ MMR (Measles, Mumps, Rubella)						
• PCV/PPSV (Pneumococcal)						
•▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐ Polio (all 3 serotypes must show immunity)

▶

Licensed Health Care Provider Signature Date

▶

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date: _____
If verified by school or child care staff the medical immunization records must be attached to this document.

structions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

print with the immunization information filled in:

k if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your ld's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the partment of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

fill out the form by hand:

Print your child's name and birthdate, and sign your name where indicated on page one.
Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides low to record each vaccine correctly. For example, record Pediatix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
f your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.

- ☐ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

f your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and e the form. You must provide lab reports with this CIS.
Provide proof of medically verified records, following the guidelines below.

ceptable Medical Records

vaccination records must be medically verified. Examples include:

A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.

A completed hardcopy CIS with a health care provider validation signature.

A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

nditional Status

ldren can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum ervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or ld care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

dents in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is ching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

he 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid umentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

ference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

ade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
HIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
acel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
uria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
xsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
ostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
varix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
otacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
erix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

ou have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

Certificate of Exemption—Medical

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings.

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in their judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 28A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Vaccine Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

*Please indicate which vaccination the **medical** exemption is referring to by disease. If the patient is not exempt from certain vaccinations, mark "not exempt.":*

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
Diphtheria	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Hib	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal	☐	☐	☐	
Polio	☐	☐	☐	
Rubella	☐	☐	☐	
Tetanus	☐	☐	☐	
Varicella	☐	☐	☐	

Health Care Practitioner Declaration

I declare that vaccination for the disease(s) checked above is/are not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

X _____ _____ _____

Licensed Health Care Practitioner Name (print) | Licensed Health Care Practitioner Signature | Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

Parent/Guardian Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date

Certificate of Exemption—Personal/Religious

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: A parent or guardian may exempt their child from the vaccinations listed below by submitting this completed form to the child's school and/or child care. A person who has been exempted from a vaccination is considered at risk for the disease or diseases for which the vaccination offers protection. An exempted child/student may be excluded from school or child care settings and activities during an outbreak of the disease that they have not been fully vaccinated against. Vaccine-preventable diseases still exist, and can spread quickly in school and child care settings. Immunization is one of the best ways to protect people from getting and spreading diseases that may result in serious illness, disability, or death.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement my child be vaccinated against the following disease(s) to attend school or child care. (Select an exemption type and the vaccinations you wish to exempt your child from):

PERSONAL/PHILOSOPHICAL EXEMPTION*

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)

Measles, mumps, or rubella may not be exempted for personal/philosophical reasons per state law

RELIGIOUS EXEMPTION

☐ Diphtheria	☐ Hepatitis B	☐ Hib	☐ Pneumococcal
☐ Polio	☐ Pertussis (whooping cough)	☐ Tetanus	☐ Varicella (chickenpox)
☐ Measles	☐ Mumps	☐ Rubella	

Parent/Guardian Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner (signed below). I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date

Health Care Practitioner Declaration

I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in Washington State.

X _____ _____ _____

Licensed Health Care Practitioner Name (print) | Licensed Health Care Practitioner Signature | Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

RELIGIOUS MEMBERSHIP EXEMPTION

Complete this section ONLY if you belong to a church or religion that objects to the use of medical treatment. Use the section above if you have a religious objection to vaccinations but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses.

Parent/Guardian Declaration

I am the parent or legal guardian of the above-named child. I affirm I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment to my child. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____

Parent/Guardian Name (print) | Parent/Guardian Signature | Date