BEAR VALLEY COMMUNITY NURSERY SCHOOL

CO-OP in the PINES

Application for Enrollment

Dear Parents,

Thank you for your interest in Bear Valley Community Nursery School, Co-op in the Pines. Your application forms are enclosed. We realize our application is extensive, but all of these forms are required either by the State of California or our nursery school.

TO BE COMPLETED BY YOUR PHYSICIAN:

1) Child's pre-admission health evaluation (LIC 701)
2) Statement of Good Health for Working Parents (in lieu of LIC 503). A TB test is required after your child has been accepted for full-time enrollment.

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

1) Identification and Emergency Information (LIC 700). Be advised that no Registered Sex Offender is allowed on school property or at any school function.
2) Child's Preadmission Health History - Parent's Report (LIC 702)
3) Personal Rights (LIC 613A) *
4) Consent for Medical Treatment (LIC 627)
5) Notification of Parent's Rights (LIC 995) *
6) Criminal Record Statement (LIC 508)
7) Permission to Obtain a Background Check
8) Field Trip Consent Form
9) Picture Consent Form
10) The Co-op Commitment Form

* The Licensing Agency governing BVCNS is:

Community Care Licensing
3737 Main Street, Suite 700
Riverside, CA 92501
(951) 782-4200

PLEASE COMPLETE ALL FORMS IN FULL

Upon receiving all listed forms, your child's name will be placed on our Waiting List. The return date of your COMPLETED application will determine your place on the Waiting List.

Please mail completed application along with your application fee to the Admissions Chairperson listed in the Application Cover Letter.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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:

Vision:

Developmental:

Language/Speech:

Allergies: medicine:

insect stings:

food:

asthma:

other:

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 Practioner

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.

Statement of Good Health
For Working Parents

To meet state requirements*, a statement of good health is required for all working personnel at the Bear Valley Community Nursery School. All personnel, including applicant, of Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. In addition, a recent T.B. test is required.

Please fill out the release below if you plan on being a working parent at BVCNS.

For purposes of working at the Bear Valley Community Nursery School I,

_____, am in good general health and am free
print your name

from communicable disease and capable of performing assigned tasks.

_____ _____
Signature Date

** Per Title 22, Division 12, Chapter 1, Section 101216 (g) (3).*
Volunteers may use this form in lieu of LIC 503 Health Screening Report-Facility Personnel

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 NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

MOTHER'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 OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER 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

PERSONAL RIGHTS

Child Care Facilities

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Facilities. Each child receiving services from a child care facility 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 facilities, 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

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

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)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(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

_____ 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 WHATEVER
NAME

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
( )	( )

LIC 627 (5/01) (CONFIDENTIAL)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

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

_____ 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 WHATEVER
NAME

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
( )	( )

LIC 627 (5/01) (CONFIDENTIAL)

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: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

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.

LIC 995 (ENG/SP) (8/02) (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.

_____
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.

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? . . . . . ☐ YES ☐ NO

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . . ☐ YES ☐ NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY NAME		FACILITY NUMBER	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California or from another state or in federal court, provide the following information:

What was the offense? _____

In which state and city did you commit the offense? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed) _____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ ***Date*** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871) The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if some one in a licensed facility has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

Permission to Obtain a Background Check

(This form authorizes the church to *obtain background information and must* be *completed by the applicant. The church must keep this completed form on file for* at *least two years after requesting* a *background check.)*

I, the undersigned applicant (also known as "consumer"), authorize **BVCC** through its independent contractor, LexisNexis, to procure background information (also known as a "consumer report and/or investigative consumer report") about me. This report may include my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; and the state sex offender records.

I understand that I am entitled to a complete copy of any background information report of which I am the subject upon my request to **BVCC**, if such is made within a reasonable time from the date it was produced. I also understand that I may receive a written summary of my rights under the Fair Credit Reporting Act.

Signature: _____ Date: _____

Identifying Information for Background Information Agency
(also known as "Consumer Reporting Agency")

Print Name: _____
First Middle Last

Other Names Used (alias, maiden, nickname): _____

Current Address: _____
Street/P.O. Box City State Zip Code County Dates

Former Address: _____
Street/P.O. Box City State Zip Code County Dates

Social Security Number: _____ Daytime Telephone Number: _____

Driver's License Number: _____ State of Issuance: _____ Date of Birth: _____ Gender: ____

Field Trip Consent Form

I understand that throughout the school year my son/daughter _____ will be going on supervised field trips with Bear Valley Community Nursery School. Unless I inform the school otherwise, he/she has my permission to attend.

_____ _____

Parent/Guardian Date

The following documents are required for car pooling any children other than your own to and/or from Field Trips held throughout the year as stated above.

Please provide:

1. **Proof of Insurance:** Please provide a copy of the Declaration page of your Insurance Policy or a copy of your Insurance Card if available.

2. **Driver's License:** A copy of your current Driver's License and proof of extension, if applicable.

_____ _____

Parent/Driver Date

_____ _____

Parent/Driver Date

_____ _____

Parent/Driver Date

***** ALL DRIVERS MUST SIGN AND HAVE THE ABOVE DOCUMENTS ON FILE *****

Picture Release Form

Bear Valley Community Nursery School (BVCNS) may at times use photographs of children and parents for advertising or publicity purposes including on our website or in local newspapers or magazines. Children's names will never be used along with pictures in any public media.

Please fill out the release below if BVCNS has your permission to use your child's photo. If you would prefer that your child's photo not be used, check here:

❒ For purposes of advertising or publicity, please do not use any photos of

_____.
print child's name

**Please note that local newspapers and magazines do occasionally come to school events and take pictures of the children. Every effort will be made to notify parents when pictures are taken. It is the responsibility of the parent/guardian to notify the photographers about your preferences regarding the use of your child's picture.*

I, _____, give Bear
print your name
Valley Community Nursery School permission to use my photographic likeness in all forms and media for advertising, publicity, and any other lawful purposes.

_____ _____
signature date

I give Bear Valley Community Nursery School permission to use photographic likeness of my child,
_____, in all forms of
print child'sname
media for advertising, publicity, and any other lawful purposes.

_____ _____
signature date

I, _____, am the
print your name
parent/legal guardian of the individual named above, I have read this release and approve of its terms

_____ _____
signature date

P.O. Box 6066, Big Bear Lake, California 92315 TEL 909.585.2444 EMAIL info@bvcns.com www.bvcns.com

THE CO-OP COMMITMENT

Work in the Classroom – Parents work approximately one day for each 4 days that a child is scheduled to attend. No siblings, except young infants, are allowed at school during work days.

Hold a Chairmanship – The parents are responsible for the administration of the school. This is accomplished by each family holding a chairmanship.

Attend Parent Meetings – Attendance at monthly parent meetings is essential so that we can understand the upcoming curriculum and its requirements as well as conduct Co-op business. All new working parents must complete Orientation to learn the policies and procedures of the school. No children, except young infants, are allowed at parent meetings.

Pay Tuition – Tuition covers approximately 55% of our operating expenses. We manage to keep tuition so low SOLELY because of fundraising. Our school is completely independent – we are not state-sponsored nor are we church-subsidized.

Participate in Fundraisers – Fundraising covers approximately 45% of our operating expenses and we cannot run the school without these funds. There are usually TWO major fundraisers and TWO smaller fundraisers as determined by the school's needs. It is mandatory for all families to participate in all fundraisers. SCRIP is an additional way to easily raise funds at no cost to parents.

1. *Harvest Dinner and Silent Auction:* Obtain at least 3 items for the silent auction from vendors who have supported the school in the past. On the night of the event, come to dinner, shop, socialize and have fun with other Co-op parents and alumni.
2. *Basket Raffle:* Donate items with a minimum value of $20 so that we can then sell raffle tickets at businesses in town, to local clubs and organizations, and to our friends and family (each family is required to sell $60 worth of tickets.)
3. *Wheel-A-Thon:* Ask your family and friends to pledge money to support your child's participation in the Wheel-A-Thon. On the day of the event, decorate your child's "wheels" and come enjoy the fun time.
4. *Pizza Party:* Sell All-You-Can-Eat Pizza tickets to family, friends and alumni. That night, take the night off from cooking and enjoy a great night of fun.
5. *SCRIP:* This is an easy and profitable program that costs us nothing. We earn money for the school based on purchases at participating vendors.

I have read and understand **The Co-op Commitment** _____ _____

(Applicant Signature) (date)