

# WEST CHESTER

christian early learning center

Registration 2024-2025

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Dear Families,

Thank you for inquiring about our preschool programs at West Chester Christian. Registration for the 2024/2025 school year at WCC is now open for WCN church members, current students and siblings of current students. Registration will begin on January 22, 2024 for the community. We are looking forward to helping your child grow and learn through Christ.

Please return the completed registration packet to the preschool office. The Tuition Express form must be filled out, as your registration fee will be applied to hold your spot for the 2024/2025 school year.

If you need additional registration packets to share with coworkers, friends and neighbors, please feel free to pick one up in the preschool office. Registration information is also available on our website @ [westchesterchristian.com](http://westchesterchristian.com).

We are happy that you have chosen West Chester Christian for your child. Welcome to our WCC family.

Blessings,



Sherri Rindfleisch, Director

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West Chester Christian has a caring and committed staff dedicated to each child's educational, social, emotional, physical and spiritual development. We believe that a child is God's most precious gift. We understand parents have entrusted us to recognize and meet the unique needs of each child.

In our classrooms your child will...

- Gain independence and self confidence
- Make new friends and learn to socialize and work/play with peers
- Participate in many learning experiences from taking turns, painting, playing in the dramatic play area, building with blocks, ABC's and 123's to learning to read, we prepare them to be lifelong learners
- Experience the great outdoors in our Nature Center and learn to grow fruits and vegetables
- Learn about God through weekly Chapel Times with the Children's Pastor and Bible related stories and activities

Additional information about WCC...

- Small class ratios
  - Toddlers: 3 teachers with 12 children
  - Two's Plus: 3 teachers with 14 children
  - 3 year olds: 2 teachers with 12 children
  - 4-5 year olds: 2 teachers with 14 children
  - School Age: 1 teacher with 16 children
- Experienced/ degreed teachers
- We use Creative Curriculum
- We follow the Ohio Department of Education Early Learning Content Standards
- Breakfast and snacks included for all extended day students
- Full size gymnasium/ playground for gross motor development



REGISTRATION FORM

Child's Full Name: \_\_\_\_\_ M/F

Date of Birth: \_\_\_\_\_ Age as of August 1, 2024: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/ Guardian's Name: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

How did you learn about West Chester Christian Early Learning Center?

friend  attend church here  social media  other

We currently are: (check all that apply)

church member  current student  sibling of student  new family

I have also completed the required State Licensing Enrollment Form and agree to have all medical papers, including immunization records to WCC prior to my child attending.

I agree to allow WCC to process the \$125 per child or \$175 per family registration fee from the TUITION EXPRESS form at the time of registration to hold my child's space. The registration fee is non-refundable. The attached tuition rates will go in effect May 27, 2024.

Parent/ Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Registration received by: \_\_\_\_\_ Date \_\_\_\_\_



# PRESCHOOL WITH EXTENDED CARE

Children may attend between the hours of 6:30 AM – 5:30 PM

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## TODDLER CLASS

Child must be 18 months old by August 1, 2024/ 1:4 ratio/ 12 children per class

4/5 days	M	T	W	Th	F	___ \$300 weekly	___ \$125 registration
3 days	M		W		F	___ \$265 weekly	___ \$125 registration
2 days		T		Th		___ \$200 weekly	___ \$125 registration

## TWO'S PLUS CLASS

Child must be 28 months old by August 1, 2024/ 3 teachers/ 14 children per class

Child does not need to be potty trained, this classroom often has young 3 year olds that are not fully potty trained

4/5 days	M	T	W	Th	F	___ \$300 weekly	___ \$125 registration
3 days	M		W		F	___ \$265 weekly	___ \$125 registration
2 days		T		TH		___ \$200 weekly	___ \$125 registration

## 3 YEAR OLD Class Preschool/ plus extended care

Child must be 3 years old by August 1, 2024/ 1:6 ratio/ 12 children per class

Child must be fully potty trained

4/5 days	M	T	W	Th	F	___ \$280 weekly	___ \$125 registration
3 days	M		W		F	___ \$250 weekly	___ \$125 registration
2 days		T		Th		___ \$190 weekly	___ \$125 registration

## 4 YEAR OLD Class Preschool /plus extended care

Child must be 4 years old by August 1, 2024/ 1:7 ratio/ 14 children per class

4/5 days	M	T	W	Th	F	___ \$280 weekly	___ \$125 registration
3 days	M		W		F	___ \$250 weekly	___ \$125 registration
2 days		T		Th		___ \$190 weekly	___ \$125 registration

## **BEFORE and AFTER SCHOOL CARE**

Lakota provides transportation to and from Hopewell Early Childhood, Shawnee Early Childhood, Woodland Elementary and Union Elementary, no program available at WCC for half day kindergarten students.

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**Before school care (6:30 AM until bus arrives)**      \_\_\_ \$125 weekly      \_\_\_ \$125 registration

**After school care (bus drops off until 5:30 PM)**      \_\_\_ \$125 weekly      \_\_\_ \$125 registration

**Before and After school care**      \_\_\_ \$155 weekly      \_\_\_ \$125 registration

**My Child attends:**    \_\_\_ Woodland    \_\_\_ Hopewell    \_\_\_ Shawnee    \_\_\_ Union

**My Child is in** \_\_\_\_\_ **grade.**

On days Lakota schools are closed due to teacher workdays, snow days, holidays, Election Day, etc., your child will be charged an additional fee of \$35 per day that they attend all day child care. If your child attends a full week break, the full day care rate of \$280 will apply. If your child will not attend any days during Christmas break or Spring break you may use a vacation week.

I acknowledge the non-refundable yearly registration fee of \$125 per child or \$175 family registration will be charged at the time of acceptance into the program.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Administrative Signature \_\_\_\_\_ Date \_\_\_\_\_







Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code	Home Telephone Number		
Parent/Guardian Name #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State		Zip	
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home# <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State		Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home# <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts: Parents <u>cannot</u> be listed as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</b>					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State		Telephone Number	

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No  
 Yes - *check all that apply*     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No  
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on file.  
 N/A - program does not provide meals or snacks to the child.

Child's Name

**Diapering Statement**

Is your child toilet trained?  Yes (If yes, skip to Emergency Transportation Authorization section)  
 No (If no, fill out the following:)

The program's policy is to check diapers every \_\_\_\_ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule  I do not agree, please check my child's diaper every \_\_\_\_ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>		<b>OR</b>  Do not sign both	<b><u>Do Not Give Permission</u> to Transport</b>	
Program or Home Name WEST CHESTER CHRISTIAN			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook.  Yes  No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

**Note:**

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
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**Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):**

**Section A- EXAMINATION**

- The above named child has been examined.
- The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).
- The above named child does not have allergies OR is allergic to the following (*please list in space below*):

*Check below, if applicable:*

- Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____	Vision _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.**

**IMMUNIZATION (Complete ONLY ONE SECTION below)**

**Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:**

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

**Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:**

- The above named child has been immunized against the diseases listed above.

*If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*

Initials of Examining Health Care Practitioner

Date

**Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):**

- I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):

Signature of Parent

Date

# RELEASE FORMS

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**Field Trip Permission** - Children will go on routine walking field trips on and around the West Chester Christian Campus. They will go on weekly field trips to our gymnasium, nature center, the Clubhouse for Chapel Time, Hawks's Hall and south foyer. Occasionally, the children may walk to Chesterwood for an event, you will always be notified in advance of these events. Teachers will post outside their classroom where they are if they are not inside their classroom. If they leave the WCC Campus they will wear tags with the center's name, address and phone number. Staff/child ratios will be met at all times during field trips. Children and staff will stay together at all times. This permission slip must be signed by the parent or guardian yearly. This permission is in effect, unless we receive a written note from the parent or guardian stating otherwise.

**Social Media Release** - Throughout the school year/summer camphor teaching staff take photos and videos of children and activities. If you agree to allow West Chester Christian to photograph/video your child please check which media you approve.

- Classroom use only (class DOJO, nametags, books, crafts, etc.)
- Facebook/ Website use (names will not be used in print with photos)
- Slideshow videos for advertising purpose/ church services/ programs

**Authorized Pick-Up** - I authorize the following people to pick-up my child from West Chester Christian at any time. Please note if it is someone we do not recognize we will ask them to show photo identification.

_____	_____	_____
Name & Relationship		
_____	_____	_____

**Child's Name** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# ALL ABOUT YOUR CHILD

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This information will be shared with your child's teachers to help them get to know your child better. Please feel free to share any information you think will help us in caring and educating your child. Together we will help your child grow and learn.

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birth Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Child lives with \_\_\_\_\_

Siblings and their ages \_\_\_\_\_  
\_\_\_\_\_

Pets and their names \_\_\_\_\_

My child's favorite toy \_\_\_\_\_

My child enjoys \_\_\_\_\_

My child's favorite food is \_\_\_\_\_

My child is a good eater \_\_\_\_\_ picky eater \_\_\_\_\_

Has your child ever been in a classroom setting before? Yes \_\_\_\_\_ No \_\_\_\_\_

Any habits, dislikes or fears your child may have? Please explain how you handle them at home. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any additional information you wish to share about your child...  
\_\_\_\_\_  
\_\_\_\_\_

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We are excited to offer the safety, convenience and ease of Tuition Express<sup>®</sup>—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) West Chester Christian to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

**COMPLETE ONE SECTION ONLY** WCC only accepts VISA and MASTERCARD (\$10 processing fee per transaction)

#### SECTION A (Credit Card)

Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

#### SECTION B (Bank Account)

Your Name	Phone #			
Address	City State Zip			
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

#### For Official Use Only

Date Received
Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE MERE 555.555.5555	00226
Pay to the order of: _____ \$	Attach Voided Check Here	
Deposit slips not accepted _____ Dollars		
⑆123456789⑆	1800330*	0226
Routing Number	Account Number	Check Number

A service of



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