PRESCHOOL

Pre-Kindergarten Program

Registration Packet 2019/2020

...where swimming is part of the curriculum.

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Due: Time of Enrollment

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Due: By August 31, 2019

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Due: By August 31, 2020

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Samena Swim and Recreation Club
15231 Lake Hills Blvd. Bellevue, WA 98007
Phone: **(425) 746-1160** Fax: **(425) 746-4485** www.samena.com

Preschool Coordinator: Sherie Dunn, ext.140, sheried@samena.com

PRESCHOOL

…where swimming is part of the curriculum.

Pre-Kindergarten Program

Thank you for enrolling in the Samena Preschool Pre-Kindergarten Program. We take pride in offering quality, well-rounded programs that have been teaching children for 50 years. A unique benefit to our curriculum is a swim lesson with trained swim instructors included at the end of the day, Monday through Thursday.

Children must be 5 years old by January 31, 2020 and fully toilet trained to be eligible for enrollment. Our classroom maintains a 1:10 teacher to student ratio with a teaching team that is experienced, creative and caring. Age-appropriate activities include: art, reading and writing skills development, number recognition, music, science, cooking, storytelling, health & exercise, and an enhanced Pre-K curriculum that will allow students to be more than ready to enter Kindergarten.
Tuition rates are on a monthly basis. Tuition and curriculum are based on a ten-month program. Our holiday and vacation schedules closely follow the Bellevue School District calendar.

Enrollment & Fees for School Year 2019/2020:
Afternoon Session: 1pm – 4pm

Monday - Thursday
or
Monday - Friday

Morning Session: 9am– 12pm

Monday/Wednesday/Friday
or
M/W/F Pre-K and T/TH 3-5's

Monthly Tuition rates:

	Member	Program Member
5 days per week Pre-K:	$ 610	$ 820
5 days Pre-K + 3-5's:	$ 595	$ 785
4 days per week:	$ 475	$ 625
3 days per week:	$ 390	$ 505

1. A non-refundable $110 registration fee must accompany the completed Pre-K Registration Form and Preschool Program Contract. These 3 items will reserve your spot.
2. September 2019 (first month) and June 2020 (last month) tuitions are due by June 1, 2019.
3. In the event of a waitlist, a $110 waitlist fee is required. If we are unable to secure you a place in the preschool by August 1, 2019, the fee is refundable. If we have a space for your child and you choose not to enroll, the fee is non-refundable.
4. Cancellation policy: Withdraw by June 30, 2019 and the last month tuition will be refunded. As of July 1, 2019, there are no refunds.
5. School forms will need to be completed for all enrolled students prior to attending in September.
6. It is suggested that parents complete an Authorization Agreement for Automatic Payment (page 10 **or** 11) to have Tuition automatically deducted each month.

Keep this page for your records. The above information also appears on the Program Contract (copy on reverse), which you will sign & submit at time of Enrollment (page 5)

PRESCHOOL

Pre-Kindergarten Program Contract 2019-2020

PARENT COPY

Original must be signed on Reverse of Registration Form, page 5

Thank you for choosing the Samena Preschool. We look forward to having your child in our program this school year. Please read and sign this form and return with your Preschool Registration Form. The remaining forms may be submitted by August 31, 2019.

Payment Policy:

- **Registration Fee:** A non-refundable $110 registration fee must accompany a Preschool Registration Form and Preschool Program Contract.
- **September 2019** (first month) and **June 2020** (last month) tuitions are due by **June 1, 2019**.
- **Tuition payments** are due by the first of the month.
- **Monthly tuition** is calculated based on the total cost of the school year and then divided equally by 10 months. This allows all monthly payments to be the same regardless of the number of days in the month. There is no change in tuition due to family vacations, time off, etc.
- **Cancellation Policy:** Once paid, the first month's tuition is non-refundable. Withdraw by June 30, 2019 and the last month's tuition will be refunded. After July 1, 2019, there are no refunds.
- **Withdrawal Policy:** Written notice must be delivered to the Preschool Coordinator at least 30 days before the 1st of the month from which you are withdrawing from the program or changing days. Our preschool program is designed to operate on the school year calendar with a commitment for September through June.

Additional Fees:

- **Waitlist Fee:** In the event of a waitlist, a $110 waitlist fee is required. If we are unable to secure you a place in the Preschool by August 1, 2019, this fee is refundable. If we have a space for your child and you choose not to enroll, the waitlist fee is non-refundable.
- **Late Pick Ups:** Our class program ends at 4:00pm. A fee is charged at a rate of $10/per each 10 minute increment you are late past the end of the program. The late fee is paid the day of the occurrence at the front desk and is not prorated. Please call if you will be late for any reason.

Additional Information:

- **Medication:** If your child requires medication, the medication information sheet must be completed, available from the lead teacher, authorizing Samena staff to administer medications to your child. Medication must be provided in its original container with written directions and dosing instructions for your child.
- **Communication:** For your child's safety, we ask that you provide in writing any changes to your emergency contacts including address and phone changes. A communication change form is available from the lead teacher.
- **Promotions materials:** We request permission for the Samena Club to use any pictures or video taken of your child in future promotional materials for the Samena Club only. Samena would have exclusive use of the photographs or videos; no photos will be sold. If you wish for your child to not be included in any promotional materials, please indicate this on Promotions Use Permission Form located in this packet and return by August 31, 2019.

My Signature on the original indicates that I/we agree to the Terms of the Samena Club Preschool, as listed on this contract. I have read and understand the terms of this agreement. I agree that I and all persons participating in the Samena Club Preschool are bound by and shall comply with the rules and regulations of the Samena Club as they may be amended from time to time.

SAMENA
• SWIM & RECREATION CLUB •

FOR OFFICE USE
Member #: ______________
Non Member ID #: ___________
Input in Preschool Database: _____

PRESCHOOL
Pre-Kindergarten Program
2019-2020 REGISTRATION FORM

Program Contract must be signed on the Reverse of this Form at time of Registration*
Additional forms need to be completed prior to the school year

□ Member □ Non-Member

Child's Name: ____________________________________ □ M □ F

Birth Date: ___/___/___ Age at start of school: _________

Home Phone: __________________ Cell Phone: ___________________

Parent/Guardian: _____________________ Occupation: ____________

Parent/Guardian: _____________________ Occupation: ____________

Home Address: ____
Street Address City/Zip

Email Address: ____

Does your child have previous preschool experience? □ Yes □ No

Has your child had previous swim instruction? □ Yes □ No

Please confirm your session:

□ **5** days, Mon – Fri PM □ **5** days, Mon – Fri AM

□ **4** days, Mon – Thurs PM □ **3** days, M/W/F AM

Registration information: 425.746.1160 ext. 0; email sheried@samena.com

--For Office Use Only--

Registration Fee: Date: ___________ $ ___________ Pay Method*: __________ Received by:__________

First Mo. Tuition: Date: ___________ $ ___________ Pay Method*: __________ Received by:__________

Last Mo. Tuition: Date: ___________ $ ___________ Pay Method*: __________ Received by:__________

For Pay Method, please write: 'CC", 'Ck #'** or ***'Cash'

---Wait List---

Wait List Deposit: Date: ___________ $ ___________ Pay Method*: __________ Received by:__________

PRESCHOOL
Pre-Kindergarten Program Contract 2019-2020
SAMENA COPY

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My Signature below indicates that I/we agree to the Terms of the Samena Club Preschool, as listed on this contract. I have read and understand the terms of this agreement. I agree that I and all persons participating in the Samena Club Preschool are bound by and shall comply with the rules and regulations of the Samena Club as they may be amended from time to time.

Parent/Guardian Name: ________________________________ Child's Name: ____________________

Signature: ____ Date: ______________________

PRESCHOOL
2019-20 MEDICAL & CONTACT INFORMATION

Please print and complete all details.

Participant's Name: ____

Date of Birth: _____/______/______ **Gender**: □ **Male** □ **Female**

Parent/Guardian's Name: ____

Address: ____

City: ____________________________________ **Zip:** _________________

Home Phone: (______) _________________ **Day Phone**: (_____) ____________________

Cell Phone: (______) _________________ **Email Address:** ________________________

Participant's Medical Information:

1. Physician's Name: _______________________________ Phone: (____) ______________
2. Date of last physical/Doctor appointment: _______________________
3. Is your child currently taking any medications? □ No □ Yes **If Yes, please describe:**
   ____
   Dosage: ____
4. Does your child have any allergies? □ No □ Yes **If Yes, please describe:**
   ____
5. Hospital Preference: ____
6. Is there other information (or special needs) which the teaching staff should be aware of?
   ____
   ____
7. Brothers/sisters & ages? ____

Emergency Contact Information

In case of an emergency, the Samena Staff is directed to call 911 immediately, then the parent or guardian. If you cannot be reached, please list two people most likely to be home and able to assist your child.

Name: ________________________________ **Relation**: ______________________________

Phone: (day) ___________________________ Phone: (other) ____________________________

Name: ________________________________ **Relation**: ______________________________

Phone: (day) ___________________________ Phone: (other) ____________________________

Authorized People Allowed to Pick up My Child:

Name: ________________________________ **Relation**: ______________________________

Phone: (day) ___________________________ Phone: (other) ____________________________

Name: ________________________________ **Relation**: ______________________________

Phone: (day) ___________________________ Phone: (other) ____________________________

Name: ________________________________ **Relation**: ______________________________

Phone: (day) ___________________________ Phone: (other) ____________________________

• SWIM & RECREATION CLUB •

PRESCHOOL
Consent to Medical Care & Treatment of Minor Children

I, ______________________________ (parent/legal guardian), hereby give

permission that my child, ____________________________, may be given emergency treatment to include first aid and CPR by a qualified staff member at Samena Club. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health in case I cannot be contacted. I waive my right of informed consent to such treatment.

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

____ ______________

Signature of Parent/Guardian Date

Promotions Use Permission

Samena Club requests your permission to use your son or daughter's photograph in Samena promotions materials. Periodically we take pictures and videos for commercial use of the children during their preschool activities. We use these for our brochures and other Samena Club advertising. Samena has exclusive use of the photographs or videos.

_____ Yes, this is acceptable.

_____ No, this is not acceptable.

____ ______________

Signature of Parent/Guardian Date

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:
Reviewed by: ______ Date: ______
Signed Cert. of Exemption on file? ❑ Yes ❑ No

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

Child's Last Name: ______ **First Name:** ______ **Middle Initial:** ______ **Birthdate** (MM/DD/YY): ______ **Sex:** ______

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

______
Parent/Guardian Signature Required **Date**

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

______
Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for 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 / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / 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)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity
Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	______
❑ Hepatitis B	❑ Rubella	______
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

______
Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

______
Printed Name

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

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child'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 Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: 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 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**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare 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.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

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

AUTHORIZATION AGREEMENT FOR CREDIT or DEBIT CARD (EFT) AUTOMATIC PAYMENTS

For Automatic Payment from Bank Account (ACH), please fill out reverse side instead

Company: **SAMENA CLUB**

I (we) hereby authorize Samena Club or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated below for monthly payment.

Credit/Debit Card type: (Please circle one) Visa Mastercard Discover AmEx

- Last 4 digits of credit card # ___ ___ ___ ___
- Expiration Date: ___ ___/___ ___
- CVV# (3 or 4 digits): ___ ___ ___ ___
- Name on Card: ____
- Street Address credit card statement is sent to: _________________________________
- Zip Code: _______________

This authority is to remain in full force and effect until Samena Club has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and the DEPOSITORY a reasonable opportunity to act on it. If I change the account number or financial institution specified, I will provide written authorization for the change to Samena Club.

Membership Number: __________________________________

Primary Member Name: (Please Print) ____

Primary Member Signature: _______________________________Date Signed:____________________

Spouse: (if applicable)

Spouse Name: (Please Print or Type) ____

Spouse Signature: ____Date Signed: __________________

15231 Lake Hills Blvd. Bellevue WA 98007
Attn: Rachel Perez (425) 746-1160 ext 124 rachelp@samena.com

AUTHORIZATION AGREEMENT FOR
ACH (Bank Account) AUTOMATIC PAYMENTS

For Automatic Payment from Credit/Debit Card (EFT), please fill out reverse side instead

Company: **SAMENA CLUB** **Type of Account:** ☐ **Checking** ☐**Savings**

I (we) hereby authorize Samena Club to initiate an electronic debit to my (our) account identified below and its depository (bank), to debit the same to said account.

Depository Name: ______________________________Branch ___________________________

City, State, Zip:

____

Transit/Routing No. ☐:__ __ __ __ __ __ __ __ __ ☐: Account No. _________________________
(first 9 numbers on bottom left of check)

I have read and agree to the terms of this application. This authorization is to remain in full force and effect until Samena Club and its DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and its DEPOSITORY a reasonable opportunity to act on it.

I further understand that it is my sole responsibility to maintain sufficient available funds in my account to provide for payment to Samena Club on the due date. In the vent that there are insufficient funds in the account and my financial institution denies payment to Samena Club, I understand that Samena Club will add a $10.00 service fee to my account.

Membership Number: ___________________________________

Primary Member Name: (Please Print or Type)

____

Primary Member Signature: ______________________________Date Signed:________________

Spouse: (if applicable)

Spouse Name: (Please Print or Type)

____

Spouse Signature: ______________________________________Date Signed: ________________

(ATTACH VOIDED CHECK)

15231 Lake Hills Blvd. Bellevue WA 98007
Attn: Rachel Perez (425) 746-1160 ext 124 rachelp@samena.com