PEAK
Let the ADVENTURE begin!

2023-2024 SCHOOL YEAR

Dear Beckford Families,

Welcome to Peak Adventure's After School Enrichment Care (Adventure Care) for all student's grades TK-5! The program runs from 2:33pm-6pm (M, W, TH, F) and 1:33pm-6pm (Tue). We know how it is when choosing an after-school provider and we are very excited to have the opportunity to serve you and your children.

One of the most exciting things about the program is the themes we will be offering. Every month STEAM based activities will revolve around a new fun and exciting theme. We will be providing your child with the opportunity to learn skills in (STEAM) Science, Technology, Engineering, Art, Math, Sports and more! We will be offering different themes throughout the year to keep your child excited about Adventure Care (Under the Sea, Superhero, Survivor, Ancient Egypt, Star Wars and more). This program provides extended learning opportunities for children offering an array of hands-on activities that reinforce and complement students' regular academic programs plus homework.

After school hours are a very important part of your child's day. We want to make sure that your child participates in a developmentally appropriate and enjoyable program that balances and complements the academic experience. We look forward to getting to know you and your children as we embark on this adventure together.

Please contact Scott Bartholomew @ peakenrichment@gmail.com to request a registration packet.

Let the Adventure Begin!

Peak Programs Inc. 27-3235505 (Non-profit organization))
26802 Pine Cliff Place • Stevenson Ranch, CA • 91381
PH: 661-219-5185 • Email: peakenrichment@gmail.com
www.Peak-Adventure.com

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2023 - 2024 Tuition Schedule

ANNUAL REGISTRATION FEE: $60 (Due Upon Enrollment. Non-Refundable)

SIBLING DISCOUNT: 10% off the lesser tuition. Please note that this discount is not 10% off the combined tuition.

TUITION BREAKDOWN

Peak Adventure Care begins on the first day of school in August and ends on the last day of school in June. Tuition is based on the number of school days during the school year and does NOT include NO SCHOOL days and breaks (Fall, Winter, Spring, Summer)

Tuition is calculated annually and broken into weekly payments. As a reminder, a 2-week written notice is needed for any changes to your weekly schedule (number of days, schedule days, etc.) Includes all Minimum Days and Early Release Days There is no credit if your child does not attend.

TK - 5th Grade	Afterschool Rates
# Of Days Per Week	Weekly Cost - Afterschool (From school dismissal to 6pm)
Full Time 4/5 Days (Minimum Days Included)	$119.00
4 Days per week (Minimum Days Included)	$110.00
3 Days per week (Set Days-Parent picks days)	$99.00
2 Days per week (Set Days-Parent picks days)	$90.00

CIRCLE DAYS: M / T / W / TH / F

CIRCLE ONE (O)

$119.00 – **Full Time (4/5 days) per week** $110.00 - **4 days per week**

$99.00 – **3 days per week** $90.00 - **2 days per week**

Scholarships: Contact CCRC – 818-717-1000

PARENTS: TO FINALIZE YOUR CHILD'S REGISTRATION PACKET PLEASE INCLUDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS.

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STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

School:_____

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

Email:_____

Teacher:_____ Gr:_____

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/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'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/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

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

DATE OF ADMISSION	DATE LEFT

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Credit Card Authorization Form

Child's Name: _____ Date: _____ **BECKFORD CHARTER**

I, _____, hereby authorize this credit card to be used for childcare payments for my child's After School Program.

CREDIT CARD INFORMATION

Name as it appears on the card: _____

Credit Card Number: _____

Exp. Date: _____ Security Code: _____

Zip Code: _____ DISCOUNT: 10% OFF 2ND CHILD AND 15% OFF 3RD CHILD

DAYS PER WEEK: M / T / W / TH / F
FULL TIME 4/5 DAYS: $119 / 4 Days: $110 / 3 Days: $99 / 2 Days: $90

PAYMENT: FIRST 3 WEEKS PLUS REGISTRATION FEE
3 weeks x ($_____) x 1st child + $60 Registration fee = $ _____
3 weeks x ($_____) x 2nd child + $60 Registration fee x 10% off = $ _____
3 weeks x ($_____) x 3rd child + $60 Registration fee x 15% off = $ _____

FIRST PAYMENT AMOUNT: $ _____

Credit Card Billing Address:

Address: _____

City: _____ State: _____ Zip: ____

Telephone: _____

Cardholder Signature: _____ Date: _____

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CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S DOMESTIC PARTNER 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* MONTHS | BEGAN TALKING AT* MONTHS | TOILET TRAINING STARTED AT* 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?)
BREAKFAST
LUNCH
DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
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

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
NAME

WHATEVER 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
( )	( )

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)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter _____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____ 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:

Allergies: medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

PERSONAL RIGHTS

Child Care Centers

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

(a) Child Care Centers. Each child receiving services from a Child Care Center 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 Centers, 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

COMMUNITY CARE LICENSING

ADDRESS

39115 TRADE CENTER DRIVE SUITE 201

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
PALMDALE	93552	661-202-3318

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)
PEAK PROGRAMS INC - BECKFORD CHARTER	19130 TULSA ST PORTER RANCH 91326

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

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: COMMUNITY CARE LICENSING

   Licensing Office Address: 39115 TRADE CENTER DRIVE SUITE 201

   Licensing Office Telephone #: 661-202-3318
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.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (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.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

CHILD'S NAME: _____ **GR:** ___ **TEACHER:** _____ **DATE:** _____

_____ **2 WEEK WRITTEN NOTICE**- The 2-week notice helps us ensure proper staffing and child to staff ratios as required by the State of California. The 2-week Written Notice can be used for the following two (2) instances:
1.When a family is reducing days needed to their current schedule (i.e. going from 5 days a week to 3 days a week)
2.When a family is removing their child from the PEAK Adventure Care entirely. Families that remove their child from the program, and then return later are subject to a new registration fee.

_____**AFTER SCHOOL ENRICHMENT CARE**

All programs are open on all regular school days during the school year. Hours of operation dismissal time and remains open until 6pm. We will be open for some legal and school holidays for an **ADDITIONAL** charge. There is a **$1.00 per minute charged per family for late pick up**. If a family is late more than 3 times removal from the program may be asked.

_____**PROGRAM ACTIVITES**

PEAK Adventures After School Program offers a balance of recreational, academic, and social activities after the school day ends. The program encourages children's growth by exposing students to art, science, technology, and other educational opportunities. Homework assistance and nutritious snack provided daily by LAUSD/Beyond the Bell.

_____**BEHAVIOR MANAGEMENT**

Discipline in the program is based on an understanding of the individual child's needs and stages of development. Our goal is to develop self-discipline, responsibility for self, and respect for others. It is based on positive reinforcement, reasonable expectations, logical consequences, distraction, and diversion, if necessary, supervised removal from the group for short periods of time. If consistent behavior problems exist without parent's help, childcare services will be terminated. We always try to work with parents to share ideas and help keep consistency between home and facility.

_____**SIGNIFICANT OCCURRENCES OR PROBLEMS**

You will be notified of any significant occurrences or problems which affect your child, including exposure to communicable illnesses.

_____**PHOTO PERMISSION**

PEAK Adventures has opportunities for children to be photographed for public use. Pictures may be taken and used for promotion of activities and other marketing situations. I understand the images may also be used on social media such as Instagram and Facebook.

_____Yes, I give permission to have my child photographed for these specific uses.

_____ No, I do not give permission to have my child photographed for these specific uses.

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_____**MOVIE PERMISSION**

The children may be offered the opportunity to watch movies on the television. Movies may be brought in from home and must be rated G or PG.

_____Yes, I give my permission for my child to partake in watching movies if they so choose, He/she may watch G/PG movies.

_____ No, I do not give my permission for my child to partake in watching movies.

_____**AUTHORIZED INDIVIDUALS FOR CHILD'S RELEASE**

Children will be released only to a parent, or a person named in writing by the parent. Parents or persons named by the parent must make sure that a staff member is aware of the child's departure. We will not release a child to an unauthorized person without written permission. A phone call will not be proper notification to add someone to your authorized individual list. Individuals who are new faces to our staff, will need proper identification before a child will be released into their care.

_____**PAYMENT AND OPERATION SCHEDULE**

The registration fee is non-refundable and not applicable to tuition.

PEAK Adventures After School Enrichment Care will only be in operation on days in which school is in session for students.

If a parent picks up a child late, they will be assessed a fee of $1.00 per minute after 6pm. **If a parent fails to pick up their child (ren) by 6:30pm Child Protective Services will be contacted.**

_____This agreement and services may be terminated at any time for any of the following:

1. Failure to pay all fees.
2. Failure to conform to rules and regulations.

I (We), the undersigned parent(s) with legal custody or legal guardianship of _____ agree to pay PEAK Adventures enrichment care fees in accordance with this agreement. I (We) have read and understand all policies of PEAK Adventures After School Program.

Parent/Guardian(s):

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Printed Name	Signature	Date

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