2024-2025 SCHOOL YEAR

Dear PEAK Families,
Welcome to another exciting year at Peak Adventure's After School Enrichment Care! We're thrilled to have your children join us for enriching activities and valuable learning experiences.

Our program runs from 2:33 pm to 6:00 pm (1:33 pm to 6:00 pm on Tuesdays), prioritizing your child's safety with a low 14-1 student-to-teacher ratio and fully licensed, background-checked through the FBI, DOJ and CDSS.

For full-time enrollment, parents receive discounts on PEAK enrichment classes and camps. If full-time isn't suitable, our ENRICHMENT PLUS program offers a flexible alternative, letting you customize your child's schedule to balance commitments.

Monthly themes, covering STEAM activities, sports, and more, aim to captivate your child's curiosity and foster a love for learning. Themes like Under the Sea, Superhero, Survivor, and Ancient Egypt ensure an engaging and diverse experience.

Adventure Care goes beyond traditional programs, offering hands-on activities that reinforce your child's academic curriculum, including dedicated homework time.

We understand the importance of after-school hours in your child's development. Our goal is to provide a developmentally appropriate and enjoyable program that complements their academic experience.

Thank you for choosing Peak Adventure's After School Enrichment Care. Here's to a year filled with growth, exploration, and fun!
Any questions contact Scott Bartholomew at peakenrichment@gmail.com.

Let the Adventure Begin!

Peak Programs Inc. 27-3235505 (Non-profit organization))
26802 Pine Cliff Place, Stevenson Ranch, CA • 92625
PH: 661-219-5185 • Email: peakenrichment@gmail.com
www.Peak-Adventure.com

2024 - 2025 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 for the upcoming school year starts on the first day of school and ends on the last day of school.
On May 20th, 2024, the initial 3 weeks and registration fee will be charged to secure your child's spot. Tuition is based on school days, excluding breaks, and is divided into weekly payments. Changes to your child's schedule require a 2-week' notice. Tuition covers Minimum Days and Early Release Days, and no credit is provided for non-attendance.

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)	$105.00
4 Days per week (Minimum Days Included)	$99.00
3 Days per week (Set Days-Parent picks days)	$95.00
2 Days per week (Set Days-Parent picks days)	$85.00

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

CIRCLE ONE (O)

$105.00 – **Full Time (4/5 days) per week** $99.00 - **4 days per week**

$95.00 – **3 days per week** $85.00 - **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

COLFAX CHARTER

OF DAYS ____
M / T / W / TH / F
EMAIL:____________________
TEACHER:____________________ GR:____

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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/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

Credit Card Authorization Form

Child's Name: ________________________________ Date: _____________ **COLFAX 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: $105 / 4 Days: $99 / 3 Days: $95 / 2 Days: $85

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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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
( )	( )

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

PEAK PROGRAMS INC - COLFAX CHARTER (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from ____ : ____ a.m./p.m. to 1PM a.m./p.m., 6PM 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 (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
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

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

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
300 CONTINENTIAL BLVD #290 A

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
EL SEGUNDO	90245	424-301-3077

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	11724 ADDISON ST VALLEY VILLAGE 91607

(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: 300 CONTINENTIAL BLVD #290 A EL SEGUNDO 90245

   Licensing Office Telephone #: 424-301-3077

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.

PEAK PROGRAMS INC
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: ______

PEAK Adventures After School Program Parent Agreement

2 WEEK WRITTEN NOTICE

To maintain proper staffing and adhere to child-to-staff ratios mandated by the State of California, we require a 2-week written notice for specific changes:

1. If you are reducing your child's attendance days (e.g., from 5 days to 3 days a week).
2. If you plan to withdraw your child entirely from PEAK Adventure Care.

Families returning after withdrawal may be subject to a new registration fee.

AFTER SCHOOL ENRICHMENT CARE

Our program operates on regular school days until 6 pm. Additional charges apply for legal and school holidays. Late pick-up incurs a $1.00 per minute fee, and repeated tardiness may result in program removal.

PROGRAM ACTIVITIES

PEAK Adventures offers a balanced mix of recreational, academic, and social activities. We expose students to art, science, technology, and homework assistance, along with a daily nutritious snack provided by LAUSD/Beyond the Bell.

BEHAVIOR MANAGEMENT

Discipline is based on understanding each child's needs and development stage. We focus on self-discipline, responsibility, and respect. Parental involvement is crucial, and consistent behavior issues may lead to termination of childcare services.

SIGNIFICANT OCCURRENCES OR PROBLEMS

Parents will be promptly notified of any significant occurrences or problems affecting their child, including exposure to communicable illnesses.

PHOTO PERMISSION

We may capture and use photos for promotional and marketing purposes, including social media. Please indicate your preference:

- [ ] Yes, I give permission.
- [ ] No, I do not give permission.

MOVIE PERMISSION

Children may watch G/PG-rated movies. Please specify your preference:

- [ ] Yes, I give permission.
- [ ] No, I do not give permission.

AUTHORIZED INDIVIDUALS FOR CHILD'S RELEASE

Children will only be released to authorized individuals listed in writing by parents. New faces require proper identification. A phone call will not add someone to the list.

PAYMENT AND OPERATION SCHEDULE

- Registration fee is non-refundable and not applicable to tuition.
- PEAK Adventures operates on school days. Late pick-up incurs a fee.

TERMINATION OF AGREEMENT

This agreement may be terminated for:

1. Failure to pay fees.
2. Failure to adhere to rules and regulations.

I (We), the undersigned parent(s) with legal custody or legal guardianship of ______________________________, agree to abide by PEAK Adventures' policies and pay fees according to this agreement.

Parent/Guardian Name: ___________________________ Date: _______________

Parent/Guardian Name: ___________________________ Date: _______________

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