PEAK

STEM AFTER SCHOOL PROGRAM

PEAK ADVENTURE'S AFTER SCHOOL CARE

2026-2027 School Year Registration Packet

Dear PEAK Wilbur Families,

Welcome to another exciting year at **PEAK Adventure's After School Care**! We are thrilled to have your children with us for enriching activities, valuable learning experiences, and unforgettable adventures.

📌 **Important: New State Forms Required**

The State of California has introduced **new childcare forms** that must be completed by **ALL families**, regardless of past enrollment. These forms are mandatory to ensure compliance with updated licensing regulations.

2026 - 2027 Tuition Schedule and Policy

Our program offers a nurturing and engaging environment with the following features:

- **Program Hours**: AM TIMES: 7AM-8AM **(Requires 10 students to run AM Care)** PM TIMES: 2:29 PM – 6:00 PM (1:29 PM – 6:00 PM on Tuesdays).
- **Low Student-to-Teacher Ratio**: A safe 14:1 ratio with all staff fully licensed and background-checked through the FBI, DOJ, and CDSS. All staff members are Child and Adult CPR, Basic First Aid, AED certified.
- **Homework Assistance**: Dedicated homework time every day to support your child's academic success.
- **Snacks Provided**: Beyond the Bell will provide a nutritious hot snack daily for all students.

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- **Enrichment Discounts**: Full-time enrollment includes discounts on PEAK enrichment classes and camps.
- **Monthly Themes**: Engaging and diverse activities, including STEAM projects, Future Innovators Lab, Mystery & Imagination, Brain Boost and Around the World Activities.

At PEAK, we aim to complement your child's academic experience by offering developmentally appropriate and fun hands-on activities that spark curiosity and inspire a love for learning.

If you have any questions, please feel free to contact **Scott Bartholomew** at peakenrichment@gmail.com.

We are excited to welcome your family to Peak Adventure Care for the upcoming school year, running from the first day of school to the last. Below is the tuition breakdown and important policy information:

- **Annual Registration Fee**: $75 (Due upon enrollment and is non-refundable).
- **Sibling Discount**: Families with multiple children receive 10% off the lesser tuition. Please note this discount is applied to the smaller tuition amount, not the combined total.

Initial Payment Includes:

- The first 3 weeks of care + $75 one-time registration fee (non-refundable)

Tuition Details:

- Tuition is calculated based on school days (38 weeks), excluding school breaks, and divided into weekly payments. No Refunds.
- To secure your child's spot, the initial 3 weeks of tuition and the registration fee will be charged.
- **Full Time Tuition (4/5 days)** covers **Minimum Days** and **Early Release Days**.
- **2/3-day options** have an additional charge of **$20 per Minimum Day or Early Release Day**.
- No credits or refunds are provided for non-attendance.
- Schedule changes or Cancellation requires **30-day notice**.

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Closure and Make-Up Policy: If LAUSD closes schools due to weather, emergencies beyond our control (strike), there will be no refunds. We will do our best to provide a make-up day; however, if the session runs out or the school calendar ends, no make-up day will be offered. No Refunds.

We appreciate your understanding and cooperation as we strive to maintain the quality of our programs while adhering to scheduling constraints.

Thank you for choosing PEAK Adventure for your child's after-school enrichment experience!

Scholarships:

- **CCRC:** 818-717-1000
- **DCFS:** 800-540-4000

Exciting News from PEAK Adventure!

Initial Payment Includes:

- The first 3 weeks of care + $75 one-time registration fee (non-refundable)

Let's make this school year the best—and most affordable—one yet!

TUITION BREAKDOWN 2026 – 2027 SCHOOL YEAR – AM CARE NEEDS 10 STUDENTS TO RUN

TK – 5TH GRADE	AFTERSCHOOL RATES
# OF DAYS PER WEEK	WEEKLY COST – AFTER SCHOOL DISMISSAL TO 6PM
FULL TIME 4/5 DAYS (MINIMUM DAYS INCLUDED)	AM $165 / PM $125 / BOTH $260
4 DAYS (MINIMUM DAYS INCLUDED)	AM $165 / PM $120 / BOTH $240
3 DAYS (SET DAYS PARENTS PICK)	AM $125 / PM $115 / BOTH $225
2 DAYS (SET DAYS PARENTS PICK)	AM $125 / PM $110 / BOTH $200

PEAK PROGRAMS INC (NON-PROFIT ORGANIZATION) EIN 27-3235505
11 MAINSAIL DRIVE CORONA DEL MAR, CA 92625
CONTACT SCOTT BARTHOLOMEW: PEAKENRICHMENT@GMAIL.COM / 661-219-5185

PEAK

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BANK AUTHORIZATION FORM

Due to more fraud from credit cards our system will not allow PEAK to add your credit card to the system. However, adding to your bank account you will not have to pay the 3% fee to the credit card company.

I, _____ hereby authorize this bank account to be used for childcare payments for my child (ren) after school program.

CIRCLE DAYS: M / T / W / TH / F – **NUMBER OF DAYS:** ____ **AM or PM or BOTH**

CIRCLE PACKAGE: 4/5 DAYS: AM: $165 PM $125 BOTH $260, **4 DAYS** AM: 165 PM $120 BOTH $240

3 DAYS: AM: $125 PM $115 BOTH $225, **2 DAYS**: AM $125 PM $110 BOTH $200

School: Wilbur Charter

Child's Name: _____ Gr: ___ Teacher: _____

BANK INFORMATION

Name as it appears on Bank Account: _____

Route # _____

Account # _____

Account Type: Saving / Checking / Corporate Saving / Corporate Checking

Address: _____

City: _____ State: ___ Phone #: _____

Signature: _____ Date: _____

PAYMENT: FIRST 3 WEEKS PLUS REGISTRATION FEE

3 Weeks X ($_____) X 1st Child + $75 Registration Fee = $_____

3 Weeks X ($_____) X 1st Child + $75 Registration Fee X 10% Off = $_____

3 Weeks X ($_____) X 1st Child + $75 Registration Fee X 15% Off = $_____

FIRST PAYMENT AMOUNT: $_____ **DATE RECEIVED: __/__**

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State of California – Health and Human Services Agency | California Department of Social Services

WILBUR CHARTER SCHOOL

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

To Be Completed by Parent or Authorized Representative

TEACHER: _____
GR: _____
EMAIL: _____

CHILD'S NAME	LAST		MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

WILBUR CHARTER SCHOOL

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE 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?)	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 / AUTHORIZED REPRESENTATIVE 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/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE 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

PEAK PROGRAMS INC
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

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 _____ : 1 a.m./p.m. to 6 a.m./p.m., 5 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

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 #290A 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

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:

Department of Social Services/

NAME

Community Care Licensing

ADDRESS

300 CONTINENTIAL AVE SUITE 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	5213 CREBS AVE TARZANA CA 91356

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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