

Wood River Preschool
1116 Main Street/PO Box 208
Hope Valley, RI 02832
(401)539-3150
djmcbride23@gmail.com

2026/2027 Annual Tuition

Application Fee of \$100 (non-refundable) due upon receipt of invoice

Please place a check mark next to class choice & payment plan option:

___ **3/4 year-old Program: Tues. & Thurs. ----- 8:30am - 11:30am -- \$2680/year**

___ \$297.50/month - (9 monthly payments) - June 1st 2026 - February 1st 2027

___ \$268.00/month - (10 monthly payments) - June 1st 2026 - March 1st 2027

___ \$244.00/month - (11 monthly payments) - June 1st 2026 - April 1st 2027

___ **4/5-year-old Extended Enrichment Program: MWF ----- 8:30am - 2pm -- \$4740/year**

___ \$526.50/month - (9 months) - June 1st 2026 - February 1st 2027

___ \$474.00/month - (10 months) - June 1st 2026 - March 1st 2027

___ \$431.00/month - (11 months) - June 1st 2026 - April 1st 2027

****Children must be age 4 by Sept. 1st to enroll in MWF Class ****

WRPS Annual Enrichment Fee: Tues. & Thurs. Program/MWF Program ----- \$300/year
(In lieu of Fundraising)

\$150 - 1st payment due October 15th 2026

\$150 - 2nd payment due February 15th 2027

Referred

By: _____

Please Circle: WRPS Website-Child Outreach-Family-Friend-Neighbor-Other

****Application Fee of \$100.00 (non-refundable) due upon receipt of invoice****

****Tuition may be subject to change** (at the discretion of WRPS Board of Directors & based on enrollment)**

****10% sibling discount applied to lowest tuition amount****

****Prior to first day of attendance - copies of recent physical, updated immunizations & proof of lead test are required****

****DHS requires evidence of annual Flu Shots - due by December 31st**

****Please keep your child's authorized pick-up information up-to-date at all times - WRPS will not release your child to anyone not listed on the form.****



Rhode Island Department of Human Services

Licensed Child Care: Enrollment/Emergency Contact Form

Updated 2/2023

Child Information							
Child's Full Name:				Enrollment Date:			
Date of Birth (MM/DD/YYYY):			Sex:		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Primary Language:				Secondary Language:			
Primary Address							
Number and Street:							
City/Town:			State:		Zip:		
School Information							
<input type="checkbox"/> N/A (Child does not attend an additional program)							
School/Program Name:				Phone: () -			
Number and Street:							
City/Town:			State:		Zip:		
Parent/Guardian 1 Information							
Parent/Guardian Full Name:							
Parent/Guardian Role: <input type="checkbox"/> Mother/Father <input type="checkbox"/> Step-Mother/Step-Father <input type="checkbox"/> Foster Parent							
<input type="checkbox"/> Other: _____							
Contact Information							
Primary Phone:		() -		<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home			
Secondary Phone:		() -		<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home			
Email:							
Home Address							
<input type="checkbox"/> Same as Child							
Number and Street:							
City/Town:			State:		Zip:		
Employer Information							
Employer Name:							
Address:							
City/Town:			State:		Zip:		
Typical Schedule							
Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:							

Child Information Form

Child's Name: _____

Parent/Guardian 2 Information							
Parent/Guardian Full Name:							
Parent/Guardian Role:		<input type="checkbox"/> Mother/Father <input type="checkbox"/> Step Mother/Step Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____					
Contact Information							
Primary Phone:		() -		<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home			
Secondary Phone:		() -		<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home			
Email:							
Home Address							<input type="checkbox"/> Same as Child
Number and Street:							
City/Town:				State:		Zip:	
Employer Information							
Employer Name:							
Address:							
City/Town:				State:		Zip:	
Typical Schedule							
Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:							

Additional Members of Child's Household	
Full Name:	Relationship:

Child Enrollment Form

Child's Name: _____

Emergency Contact Information 1 (other than parent/guardian listed above)			
Full Name			
Relationship	<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact only		
Primary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home
Secondary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home

Emergency Contact Information 2 (other than parent/guardian listed above)			
Full Name			
Relationship	<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact only		
Primary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home
Secondary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home

Emergency Contact Information 3 (other than parent/guardian listed above)			
Full Name			
Relationship	<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact only		
Primary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home
Secondary Phone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work	<input type="checkbox"/> Home

Parental Access Restrictions
If there are temporary or permanent restrictions on a person's access to your child, please read and complete this section thoroughly and provide all requested documentation. If the restricted person(s) are a child's biological parent(s) programs MUST have received a copy of any/all court documentations regarding restraining orders, physical/legal custody, joint custody, etc. Without court documentation, programs/providers are unable to withhold a child from their biological parent.

Restricted Person's Name:	Relation to Child:					
Documentation Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A						
The above stated person has permission to see the child on the following days:						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Acknowledgment
By signing this form, I acknowledge that the information contained in this document is true and accurate. I understand that it is my responsibility to update the program/provider in the event of any changes or updates

Parent/Guardian Name (Print) _____
Relation to Child

Parent/Guardian Signature _____
Date

Child Information Form

Child's Name: _____

Child's Nickname(s) _____

Social Emotional Development:

Please describe your child's personality:

Please describe any fears your child has that may affect his/her behavior at preschool, or that you wish for us to be aware of:

Please describe how you comfort your child when he/she is upset:

Please describe how you guide your child's behaviors:

Please describe your child's interests, favorite toys/activities:

Please list any previous group activities your child has been involved in (childcare, library story hour, dance, sports, etc.):

Health/Physical Development:

Primary language spoken in the home? _____

Secondary language spoken in the home? _____

Please describe your child's speech: distinct/developing but understandable/difficult to understand

Please share any other information such as he/she is receiving speech services, etc.

Has your child received services from Early Intervention, Child Outreach, or other Association? If so, please describe the services received, and the developmental areas addressed:

Does your child have any special physical conditions and/or special needs we should be aware of?

Please describe your child's eating habits: Does he/she sit during meals? Does he/she need reminders to bite, chew, then swallow food, etc.?

Does your child still nap? Is there any information you wish to share about his/her sleeping habits?

Please share any special concerns about your child's development, schedule, relationships, etc., you wish for us to be aware of:

Please share any additional information about your child which may help in caring for him/her:

Bathroom Habits:

Is your child toilet trained? Yes No Close

Does your child use the toilet regularly? Yes No

Does your child tell you when he/she needs to use the bathroom? Yes No

If yes, please describe how:

WRPS is licensed by DHS. In accordance with DHS regulations, children who enroll in our program must be potty trained by September 1st. Your child should be able to independently climb on/off a toilet, and be comfortable sitting on a toilet (we are not allowed to offer potty chairs or potty seats). Children must be experienced with their clothing enough to independently use the toilet (pants with elastic waist help). Teachers may help with clothing when necessary - outside of the bathroom stall. Pull-ups/diapers are not allowed to be worn at WRPS, as we do not have the facility space for a changing table, special waste receptacle, or an extra sink available for adult use only (all of which are required by DHS in order to enroll children who wear pull-ups/diapers).



Rhode Island Department of Human Services

All Providers: Parent Authorization for Emergency Treatment

Updated 01/12/2023

Please ensure that all information on this sheet is completed to comply with regulations.

Authorization Statement		
Family Child Care/ Child Care Center Provider Name:		
Address of Child Care Provider:		
Child's Name:	Date of Birth:	
<p>In consideration of admittance, I hereby authorize _____ <small>Family Child Care/Child Care Center Name</small></p> <p>located at _____ RI _____ <small>Number and Street City/Town Zip</small></p> <p>to arrange for medical examination and/or treatment of my child _____ <small>Child's Full Name</small></p> <p>should an emergency arise while my child is in the care of the above state provider/program. It is understood that a conscientious effort will be made by the provider to contact me at the emergency numbers I have provided below before any medical action is taken.</p>		
Preferred Hospital		
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.		
Name of Hospital:		
Number and Street:	State:	Zip:
Physician and Insurance Information		
My child uses the following physician for regular care and his/her insurance information is below.		
Name of Doctor:	Phone:	
Address of Physician's Office:		
Health Insurance Carrier:	Policy Number:	
Emergency Contact Information		
<p>In the event of an emergency, the child's parent/guardian(s) will be contacted first. In the event the parent/guardian cannot be reached, emergency contacts must be listed.</p> <p>Emergency Contact: An emergency contact can pick up a child from care ONLY if there is written and/or verbal communication from the parent. An emergency contact may also be contacted if the program cannot get ahold of the parent. Parents/guardians must identify two (2) adults who can be contacted in the event of an emergency if they are unreachable. This information shall be reviewed annually to update any changes.</p>		



Rhode Island Department of Human Services

All Providers: Parent Authorization for Emergency Treatment

Updated 01/12/2023

Please complete the following form listing the authorized and/or emergency contact persons in the order you wish them to be contacted.

Full Name:	
Relationship:	<input type="checkbox"/> This required emergency contact is also an authorized pickup for my child.
Address:	
Phone: () -	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:	
Relationship:	<input type="checkbox"/> This required emergency contact is also an authorized pickup for my child.
Address:	
Phone: () -	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:	
Relationship:	<input type="checkbox"/> This emergency contact is also an authorized pickup for my child.
Address:	
Phone: () -	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

_____	_____
Parent/Guardian Name (Print)	Relation to Child
_____	_____
Parent/Guardian Signature	Date



Rhode Island Department of Human Services

Licensed Child Care: Allergy Information Form

Child Information	
Child's Name:	Date of Birth:
Is your child Asthmatic? (Yes = High Risk for Severe Reaction) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Allergy Information				
Please provide as much detail regarding your child's allergies below. A child with an allergy should also have an Allergy Plan from their physician provided alongside this information form.				
Allergen	Cause of Reaction	Reaction Type	Medication on File	Notes
<i>Example: Eggs</i>	<i>Example: Ingestion</i>	<i>Example: Hives</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	<i>Example: Benadryl calms reaction</i>
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	

Posting Permission	
Please complete the following if any of your child's allergies are food related.	
Does the program have your permission to post your child's food allergy information in the licensed program space? (i.e. Post your child's name and food allergen in the food preparation or dining area for ease of reference by program staff) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician and Insurance Information	
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.	
Name of Doctor:	Phone:
Health Insurance Carrier:	Policy Number:

Parent/Guardian (Print)

Parent/Guardian Signature

Date

Field Trip Permission:

I give WRPS permission to take _____ on supervised field trips.
child's name

****This permission is required to be signed & filed in every child's folder. WRPS will never take your child on an unannounced field trip. WRPS does not transport children to/from any field trips. If transportation is required, it shall be arranged by the parent/guardian with ample notice. A minimum of two weeks notification must be given to families for all field trips.****

Signature (parent/guardian) _____

Date: _____

Information to be included on Class List:

I give WRPS permission to provide the following information on a class list to be shared with all the families in my child's class. This information is shared for the purpose of contacting families regarding play dates, help with transportation, birthday party invites, etc.

Please check all that apply:

____ Address

____ Parent's Names

____ Mom's Cell Phone

____ Dad's Cell Phone

____ Mom's Email

____ Dad's Email

Signature (parent/guardian) _____

Date: _____

Photo Consent:

I give WRPS permission to use photos of my child for:

Please check all that apply:

____ Brightwheel Platform notifications to child's family only

____ Brightwheel Platform notifications to families in my child's class (your child may be included in photos sent to families in the class)

____ WRPS FaceBook

____ WRPS Instagram

Signature (parent/guardian) _____

Date: _____