

Child File Checklist

Office Use Only



Name: _____

Date of Birth: _____

Enrollment Date: _____

Enrollment Forms:	Date Received:	Notes: (Office Use Only)
Admission Agreement (Signed)		
Photo Release (Signed)		Highlight if applicable: NO PHOTOS/SOCIAL MEDIA AT ALL
Health Policy (Signed)		
Drop Off Policy (Signed)		
Biting Policy (Signed)		
Daily Required Materials (Signed)		
Food Policy (Signed)		
Waiver and Release of Liability (Signed)		
Food Application		Upload to DropBox
Licensing Forms		
ID and Emergency Information (LIC 700)		Copy made for classroom and file
Consent for Medical Treatment (LIC627)		Copy made for classroom and file
Preadmission Health History (LIC 702)		
Parent Rights (LIC 995)		
Personal Rights (LIC 613A)		
Physician's Report (LIC 701)		(with parent and physician's signatures)
Blue Immunization Card		(signed on the back)
Immunization Record		Up to date!
Infant/Toddler Additional Forms		
Infant/Toddler Needs & Service Plan		Copy made for classroom and file Renew every 3 months
Individual Infant Sleeping Plan (LIC9227)		Only if under 12 months

Allergies:



Happy Time Preschool
4518 47th Ave.
Sacramento, CA 95824
(916) 422-6777
mj.lucas@yahoo.com

Happy Time Preschool
7610 Elsie Ave.
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(916) 689-8889
mleah.patel@gmail.com

ADMISSIONS AGREEMENT

Welcome to Happy Time Preschool! This agreement and our Parent Handbook adheres to our rules and policies. You must read and understand this agreement and the handbook, and agree to comply with them. If you have any questions, please feel free to ask.

Child's Name: _____ Date of Birth: _____

Home Address: _____
(Full Address: Including City, State, Zip Code)

Parent/Guardian 1 Name: _____

Address: _____
(If different than Child's Address. Including City, State, Zip Code)

Phone Numbers: _____ (Home/Cell) _____ (Work)

Parent/Guardian 1 Email Address: _____

Parent/Guardian 2 Name: _____

Address: _____
(If different than Child's Address. Including City, State, Zip Code)

Phone Numbers: _____ (Home/Cell) _____ (Work)

Parent/Guardian 2 Email Address: _____

By executing this Agreement you, _____,
(Parent/Guardian)
agree to enroll your child, _____,
(Child's Name)

Time Preschool. Happy Time Preschool accepts your child's enrollment under the terms and conditions stated below.

PROGRAM AND HOURS OF CARE: Happy Time Preschool has operating hours from:

Monday - Friday 7:00am - 6:00pm

— **Full Days:** Weekdays from _____ a.m. until _____ p.m. **on these days:** M T W TH F
(Circle)

— **Half Days:** Weekdays from _____ a.m. until _____ p.m. **on these days:** M T W TH F
(Circle)

— **School Age:** Weekdays from _____ a.m. until _____ p.m. **on these days:** M T W TH F
(Circle)

OFF TRACK/BREAK: _____ Full Day _____ Half Day

ON TRACK: _____ Before School _____ After School

Kinders Only: _____ AM Kinder _____ PM Kinder

Schedules may be changed with a notice in writing two weeks prior to change with a new enrollment agreement

REGISTRATION AND RE-ENROLLMENT: A non-refundable registration fee of \$100 per child is due upon acceptance into the program. Payment of this fee will place your child on a waiting list if no space is available at the time you apply. I understand that each following year, continuing families must include an annual re-registration fee.

TUITION: I agree to pay weekly tuition of \$_____ on the Friday prior to care. If payment is not received on time, a late fee of \$25 will be added on Monday at noon.. If payment is not received on Tuesday an additional \$5 will be added per day (up to 30 days). Your child may not attend until payment is made.

Tuition rates are subject to change with a minimum of 30 day notice. Tuition fee is a preferred method of payment, either cash or check. I understand that tuition is due each Friday. Partial weeks of attendance must be paid in full.

RETURNED PAYMENT POLICY: A \$35 fee will be charged for any returned check. Any time there is a returned check, a money order, cashier's check or cash will be required as a replacement. Failure to cover returned checks as stated will terminate our agreement to provide care for your child. Failure to pay an NSF check within 5 days will result in legal action. Returned checks will be sent to the District Attorneys office and a claim will be filed in small claims court.

ABSENTEE POLICY: I understand that I am responsible for full payment of tuition every week, whether or not my child attends the full week. There is no absentee credit should my child miss childcare because of holidays, vacations, illness, or any other reason.

VACATION POLICY: Happy Time Preschool Inc. allows for one week vacation after the child has been enrolled for one full year. Vacation credit must be requested a minimum of two weeks in advance.

HOLIDAYS: Happy Time Preschool will close at 12:00pm on New Year's Eve and Christmas Eve. Happy Time will be closed the entire day on New Year's Day, MLK Day, Presidents Day, Memorial Day, Juneteenth, July 4th, Labor Day, Veterans Day, Thanksgiving Day and the day after and Christmas Day and the day after depending on the day Christmas falls on.

HAPPY TIME CLOSURES: I understand that Happy Time Preschool will observe holidays during which the program will be closed, as listed above. I agree to pay full tuition for my child for all the weeks, including those with closures. Please refer to the Parent Handbook for further details.

WITHDRAWAL POLICY: I understand that I must give a minimum of two weeks written notice (14 calendar days) if I intend to withdraw my child from the program. Tuition will continue to be due for this notice period. Withdrawal forms are available per your request.

INITIATED WITHDRAWAL POLICY: Happy Time Preschool reserves the right to have any child removed from the program at any time without previous notice.

SCHEDULE CHANGE POLICY: I understand that if I wish to change my child's schedule, I will provide a two weeks notice.

LATE PICKUPS: All late fees are due upon arrival directly to Happy Time Preschool.

- Program hours are 7:00am to 6:00pm. I understand that if my child remains at school past 6:00pm (or as stated on Subsidy Contracted Schedule time restrictions) I will be charged \$5 per minute.
- If my child is left at childcare longer than thirty (30) minutes past the scheduled closing time without contact to Happy Time Preschool and the child care has exhausted all emergency options from my emergency from, then the Sacramento County Police Department will be contacted. At that time my child will be in the responsibility of the Sacramento County Police Department.
- **Late pick up fees must be paid within 72 hours and are subject to a late fee of \$25/ day after 72 hours and \$5/day up to 30 days. If unpaid after 72 hours, attendance will be denied until the account is paid in full.**

INCLEMENT WEATHER AND EMERGENCY POLICY: The center may be closed in case of inclement weather or a non-weather related emergency if the conditions for the Center's children and staff are deemed to be unsafe, or if opening the center is deemed unsafe. There will be no refund or credit for tuition fees for any such closing. In the event of an early closing due to snow or other inclement weather, or an Emergency you agree to make arrangements to pick up your child promptly when called by the center.

ACCESS OF RECORDS: The Happy Time Preschool values privacy and wants to be sure that it protects information concerning families. Happy Time may access my child's records and health information for program purposes. The California Department of Social Services Community Care Licensing Division has the right to interview children and review children's file without the permission of the parents under California regulation (section 101200).

PHOTOGRAPHY POLICY: Children are occasionally photographed/videoed in their classroom or while on the program. These photos may be used in classroom activities, our newsletter, published on our website or various other materials. I hereby grant, without limitation, permission for the use of photographs of my child in printed or online material for the school.

UPDATING OF EMERGENCY INFORMATION: It is important that Happy Time Preschool maintains current and accurate records for each child so that parents can be contacted in the event of an emergency. It is the parent/guardian's responsibility to make sure that Happy Time has current contact information. If there are any changes to this information, we must be notified so that we can update our records.

TERMINATION: This agreement shall be terminated if any of the following occur:

- Death of a child.
- Serious illness of the child preventing attendance.
- The parent/guardian allows their account delinquent.
- Failure to honor the obligations of this agreement by the parent/guardian.
- The school in its sole and unfettered discretion determines that it is not in the best interest of the school or the child enrolled at the school to have the child in attendance.
- The school determines they're unable to meet the needs of the child.
- Failure of the child's parent/guardian to cooperate with the school, which the determines in its sole unfettered discretion is serious enough to warrant termination.

The child's parent/guardian may request a conference with the school personnel regarding the matters that potentially warrant termination, but the school shall have no obligation to grant any such request. The school's director or staff shall have the sole right and responsibility to determine any disputed factual matters regarding termination of this agreement.

SUSPENSIONS: If, in the judgment of the Center Director or designee, your child's behavior interferes with the Center staff providing a safe and nurturing program, the Center will contact you to remove your child for the remainder of the school day. This includes but not limited to, hitting another child, teacher or parent on property; endangering staff members and/or children; threatening another child and/or staff members; and/or using foul language. The center requires that the child be picked up within one hour of being notified. You will be responsible for the daily tuition for that day.

OBLIGATIONS BY THE PARENT/GUARDIAN: The parent/guardian is responsible of the following:

- Provide requested medical information within 30 days of enrollment. Child's vaccinations are to be provided prior the the child's start date.
- Present the child to a staff member each morning for a health inspection, any child showing any signs of illness will not be allowed to enter.
- Shall sign the child in and out daily. This is required by Community Care Licensing.
- Bring the child to school by 9:30am. Any child arriving after 10am must provide a doctors note. Without a note the child will miss the school day. If your child will be late the school must be notified by 9:00am.
- Notify the school in writing when someone other than those listed on the emergency information form will be calling for their child.
- Have the child dressed appropriately when brought to school.
- Notify the school immediately if their child or someone in the household has been exposed to a communicable disease.
- Will pick up their child no later than an hour after being notified their child is sick.
- Will not allow their child to attend school while sick for 24 hours unmedicated showing no signs of illness.
- Will not allow their child to bring personal toys, jewelry, etc. into the school that may become lost or stolen.
- Will not bring any outside food unless for the entire classroom on special occasions (birthdays, holidays, events, etc.).
- Shall provide necessary items of care for the child (diapers, wipes, extra clothing, etc.).
- Shall respect the non-religious nature of the school program.
- Shall refrain from discipling other children.
- May not spank, hit or use foul language toward their child or any other child while on the property of Happy Time Preschool.
- Smoking is prohibited in or around the facility. This is a law set by the Community Care Licensing.
- Attend to school conferences asked by the Director.
- Shall provide a two weeks written notice upon withdrawals of their child.

OBLIGATION BY HAPPY TIME PRESCHOOL: The school is responsible for the following:

- Happy Time staff will assist with personal hygiene.
- Happy Time will provide breakfast, lunch and two snacks daily. The meals are planned from the four food groups. A menu is posted in the lobby. Allergies are listed in each classroom. Lunch from home must be nutritional.
 - Breakfast ends at 7:15am, children arriving after 7:15am must have eaten prior to attending school (excluding infants).
 - Lunch ends at 11:30am, children arriving after 11:30am must have eaten prior to attending school.

- Happy Time provides a mat, sheet and blanket for nap time. Sheets and blankets are washed weekly (daily for the infant classroom), unless soiled prior.
- Provide the opportunity to nap/rest between 12:00pm to 2:30pm daily.
- Shall place children in group of peers based on age and or special needs determined by the Director.
- Allow child to be involved in a program to play and learning experiences which are appropriate for that age. A balance of active and quiet play is provided with individual and group activities which are geared toward emotional, social and physical growth.
- Assume responsibility for the child after the child has passed the legally required morning inspection and has been signed in by the parent/guardian.
- Shall administer physician prescribed medication and over the counter medications upon written request. All medications must be in their original containers and the medicine must be age appropriate and given according to package directions unless directed by the physician in writing. Medication will be kept in the lock box out of reach of children.
- Give appropriate first aide to a hurt child. A parent/guardian will be contacted if the judgment by the staff that requires immediate medical attention. In the case of an emergency, paramedics will be called and the parent/guardian will be called immediately right after.
- Ill child will be isolated and given appropriate care until a parent/guardian picks up the child, sick children cannot remain in the facility
- Notify parents of. Suspected communicable disease.
- Make every effort to safeguard personal belongings brought by the child to school, however we will not be responsible for any lost, stolen or broken personal property.
- The Director or any staff member shall report to Child Protective Services or the Police Department as required by the State Penal Code 11166 of any suspected child abuse, sexual abuse, neglect or endangerment of which they may become aware of.

PROPERTY DAMAGE: Should your child willfully damage any of the centers property, you will be held liable for the cost of the replacement or replacing the damaged property within 30 days.

UNCLAIMED PERSONAL PROPERTY: All personal property will be donated and/or disposed of after 30 days of termination from the center.

MODIFICATION: This agreement may be modified whenever any circumstances covered by this agreement changes, such modifications may only be made in writing and dated by the parent involved in order to be binding and effective. Oral modifications are not binding under the agreement and shall not be enforceable under any condition.

I have read and initialed each section listed above. I hereby agree to comply with the rules and regulations of the school regarding fees, attendance, health, clothing and other items specified in the parent’s handbook issued by the school as indicated on the contract which I have signed. I hereby agree to notify the school in writing two weeks in advance of withdrawal from the program. I have read the statement to the effect that no refund or tuition will be given upon withdrawal unless proper notice is provided. I further agree to pay all tuition on time as listed in the parent’s handbook and agree to pay childcare whether or not my child attends.

Parent/Guardian’s Name

Parent/ Guardian’s Signature

Date

Director/Administrator’s Name

Director/Administrator’s Signature

Date



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TUITION RATES

Weekly Tuition Is Due Friday For The Upcoming Week

	Full Time (25 hours or more)	Part Time (less than 25 hours)
Infant/Toddler Age: 6 weeks - 24 months	\$400 /per week	\$320 /per week
Non-Potty Trained Age: 2 years and up	\$275 /per week	\$220 /per week
Potty Trained Age: 2 years and up	\$265 /per week	\$212 /per week
School Age Age: 6 years and up	\$255 /per week (Non-school days including minimum days)	\$210 /per week (Before and/or after school)

A *non-refundable* registration fee of \$100 per child, is due upon acceptance into the program. Registration Fee is due upon enrollment and annually.

Children attending Full time may not exceed 10 hours a day. After the 10th hour, there will be an additional charge of \$20 per day.

This tuition schedule reflects our current tuition rates when paying via check, money order, cash or through Brightwheel.

Extra fees may apply for “special” or additional field trips and must be paid in addition to regular tuition payments.

Supply fee of \$100 per child is due every September. The supply fee covers the supplies your child will need for the year.

Program tuition payments are always due in advance. Non-payment of program tuition will result in denial of services until prior account balance and prepayment of current weekly tuition is paid in full. There is no tuition reductions granted for absences, holidays, or lack of attendance in your requested program. Tuition rates are subject to change.

Child's Name: _____

Date: _____

Parent/Guardian Name: _____ Signature: _____



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PERMISSION TO PHOTOGRAPH OR VIDEO TAPE CHILD

PLEASE CHECK BOX IF YOU **DO NOT** WANT TO GIVE PERMISSION FOR YOUR CHILD TO BE PHOTOGRAPHED OR VIDEO TAPED.

- Happy Time Preschool accepts to use the photograph(s) only in printed promotional materials, parent emails, on-line publications, social media and website.
- Happy Time Preschool accepts not to disclose the name or provide any details of any child in any way to any person to entity.
- Happy Time Preschool accepts not to make any photos or video tapes of any child available to any person or entity. Internal classroom video cameras are to be for security purposes only and recordings shall be reset after 24 hours.
- Happy Time Preschool accepts not to sell any child's photographs, video tapes or examples of school work for any direct commercial gain.
- I hereby give permission for Happy Time Preschool, Inc. to photograph and use pictures and/or videos of my child and/or examples of their school work.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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HEALTH POLICY

If your child shows any signs of illness (rash, irritability, listlessness, vomiting, temperature, etc.), he/she **MUST** be kept home.

By enforcing this policy we are able to maintain a healthy environment for all children in our schools. If a child shows symptoms of an infectious illness during their stay at school, the parent/guardian will be contacted to pick him/her up within one hour from the time of telephone contact. **Failure to do so will result in termination from our program after two instances.** Children must be **symptom free** for 24 hours before returning back to school.

We may require a doctor's note upon return at the Director's discretion

The symptoms are as follows:

- Diarrhea
- Fever of 100 degrees or above
- Cough with mucus secretion
- Any unknown rash or skin infection
- Vomiting
- Pink Eye
- Head Lice, hair must be lice and nit free upon return to school
- Inconsolable, irritable discomfort
- Heavy nasal discharge indicating an infection
- Contagious illness such as Chicken Pox, Hand, Food & Mouth Disease, Impetigo, Ringworm, etc.

In the event of a pandemic the following is required if experiencing any symptoms related to the pandemic: Children must remain home at least 72 hours symptom free or 10 days from onset of the symptoms, whichever is longer. This may subject to change with guidance and information published regarding a pandemic.

Happy Time Preschool believes in and teaches a healthy living. This is integrated in our curriculum and modeled by our facility and staff. We encourage our children to make healthy decisions regarding their health.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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DROP OFF POLICY

Structure and routine are vital in a child's growth and development. It is important that Happy Time Preschool families come together to provide the best structure for the benefit of the children. The following policy will be enforced to ensure routine and stability to the program.

- If you will be arriving after 9:30am, you must notify the center what time you will arrive. You may notify the center by
 - Phone call
 - Email
 - Brightwheel App
- **No drop offs will be allowed after 9:30am without prior communication with the center.**
- You may be asked to bring a doctor's note if arriving after 9:30am.

Following these steps will lessen any disruption to the daily operations of the center as well as providing stability with the daily schedule for the children.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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BITING POLICY

Biting behavior may occur with children who do not yet have the verbal skills to communicate frustration. As much as we can understand this behavior, we need to make sure that all the children are safe in our care. Below is listed as our biting policy which will be followed:

1. Biting incidents will be documented on an Incident report.
2. We will notify you when the biting incident occurs.
3. All bites and attempted bites will be documented.
4. A plan of action will be created to curb this behavior. We need to work jointly to prevent your child from biting. We must make sure that all children are protected, and if the biting continues, we may have to ask your child to leave the school. We will do everything we can to maintain a classroom conducive to safety and success but your assistance is a vital part of this process.
5. If your child bites one time and continues to attempt to bite, you will be asked to take your child home for the day. At this point we will also align the plan of action with our behavior policy.
6. When your child returns to the school, if the biting persists, we will ask you to keep your child home for 2 days.
7. When your child returns to school, they will be placed on a two-week probation. Should your child bite at all during this time, they will be dismissed from our school.

These steps will be taken at the discretion of the Director. Due to the circumstances we reserve the right to terminate services at any time.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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DAILY REQUIRED MATERIALS

Due to limited storage and families not returning borrowed materials, we can no longer supply extras. If your child does not have the required items, you would be required to pick up your child.

Infant/Toddlers:

- Diapers
- Wipes
- Pacifier
- Bottles (Prepared with labels, first and last name and date)
- Baby Food (Prepared with labels, first and last name and date)
- Extra Clothes

2-3 year olds:

- Diapers/Pull-ups
- Wipes
- Extra underwear
- Extra Clothes

3 years olds and up:

- Extra Clothes

Please be mindful of cubby size, do not bring large quantities of items to be stored at the school.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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FOOD POLICY



7:00 - 7:15am -Breakfast

9:00am - 9:15am– Snack (Second Breakfast)

11:00am - 11:30am – Lunch

3:00pm - 3:15pm – Snack

Please feed your child accordingly before you bring him/her to Happy Time if he/she is going to miss a meal. **If you bring food from home for your child, we will give it to him/her during meal time.** If you want your child to eat it between meal times, we will ask that you sit with your child, outside of the classroom, attend to him/her while he/she eats, and then bring your child into the classroom once he/she is finished.

No unhealthy food including candy, chips, doughnuts, fast food, fruit snacks, etc.

Happy Time Preschool believes in and teaches a healthy living. This is integrated in our curriculum and modeled by our facility and staff. We encourage our children to make healthy decisions regarding diet.

Child's Name: _____

Date: _____

Parent/Guardian Signature: _____



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Waiver and Release of Liability Form

I, ON BEHALF OF MYSELF AND MY DEPENDENTS, HEREBY ASSUME ALL OF THE RISK OF REQUESTING THIS SERVICE, including by way of example and not limitation, any risks that may arise from contracting COVID-19 from my Service Provider, gross negligence or carelessness on the part of the Service Provider and releasing my Service Provider from any and all liability from any medical conditions, viruses, of the Service Provider and contracting such viruses from the Service Provider. This Waiver and Release of Liability covers any negligence or gross negligence in relation to exposing me or my dependents to the COVID-19 virus from the Service Provider while in care.

I am responsible for determine whether a physical or medical examination should be undertaken before my dependents participate in the services being provided and I will abide by any determination, limitation, or recommendation that may be issued by my medical or health care provider. Before, during, and after the services, I am solely responsible for determining mine and my defendant's health and physical status and whether I or my dependents can or should discontinue my participation in the services, or take other actions. To protect my own, and my dependents, health and safety. Service Provider assumes no duty to me to my dependents to ensure my physical or medical ability to participate in the services, whether before, during, or after the services.

I acknowledge that this Waiver and Release of Liability Form will govern my actions and responsibilities as said services, activity or event.

In consideration of providing services to me and/or my dependents, I hereby take action for myself, dependents, my executors, administrators, heirs, next of kin, successors, and assign as follows:

- (A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this event, THE FOLLOWING ENTITIES OR PERSONS: Service Provider and its directors, officers, employees, representatives, employee, and agents;
- (B) I INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this service, activity to event, whether caused by the negligence of release otherwise. My and my dependent's participation in the service is voluntary.

I acknowledge that Service Provider and its directors, officers, employees, representatives, and agents are NOT responsible for the contamination, errors, omissions, acts, or failures to act of any party or entity conducting in providing the services.

I acknowledge that this activity, event or service may carry with it the potential for death, serious injury, and property loss.

The accident waiver and release of liability shall be constructed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT, AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OG MY OWN FREE WILL.

ON BEHALF OF MYSELF AND MY DEPENDENTS

Parent/Guardian Name: _____ Signature: _____

Child's Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF LICENSING REPORTS

I, as the parent/legal guardian of _____, currently attending or newly enrolled at _____ child care center/family child care home acknowledge I have received the following information as required by Health and Safety Code sections 1596.8595 and 1596.8895.

- Copy of any licensing report that documents a Type A deficiency cited at this facility; Type A deficiencies are those that, if not corrected, represent an immediate risk to the health, safety or personal rights of children in care. This includes facility visits and substantiated complaint investigations.

Date(s) of licensing report(s) provided: _____

- Copy of licensing documents pertaining to a conference conducted by a local licensing agency management representative and the licensee of this child care center/family child care home in which issues of noncompliance are discussed.

Date of document provided: _____

- Copy of the Accusation Summary indicating the Department's intent to revoke the license of this child care center/family child care home, until that accusation is either dismissed or resolved through the administrative hearing process or stipulated agreement.

Date of document provided: _____

- As a parent/legal guardian of a newly enrolled child in this child care center/family child care home, I have been provided the documents identified above received by the licensee during the 12-month period prior to my child's enrollment.

My signature below verifies I have received the documents identified above.

PARENT/LEGAL GUARDIAN SIGNATURE:	DATE DOCUMENTS RECEIVED:
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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
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
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**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY
CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	LAST DATE OF ENROLLMENT
-------------------	-------------------------

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
()

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* _____ 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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> 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
--	------

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: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

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

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 _____

ADDRESS _____

CITY _____	ZIP CODE _____	AREA CODE/TELEPHONE NUMBER _____
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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)
----------------------------------	-------------------------------------

(PRINT THE NAME OF THE CHILD) _____

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN) _____

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

PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)
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

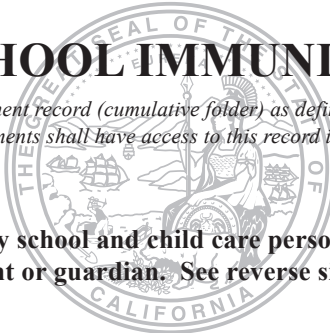
RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.



This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ Sex: M F Birthdate _____ Place of Birth _____

Name of Parent or Guardian _____ Address _____

Telephone _____ Daytime _____ Nighttime _____ City _____ ZIP _____

Race/Ethnicity:

- White, not Hispanic
- Hispanic
- Black
- Other: _____

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date _____

Staff _____

Signature _____

Record Presented was:

- Yellow California Immunization Record
 - Out-of-state school record
 - Other immunization record
- Specify: _____

II. STATUS OF REQUIREMENTS

- A. All Requirements are met.
Date _____
- B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:

- C. Medical Reasons—Permanent
- D. Medical Reasons—Temporary
- E. Personal Beliefs

III. 7th GRADE ENTRY

- A. All Requirements are met.
Name _____ Date _____
- B. Currently up-to-date, but more doses are due later. Needs follow-up.
Name _____ Date _____

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression	CHEST X-RAY (Necessary if skin test positive)
	<input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other					
<input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other					<input type="checkbox"/> Pos <input type="checkbox"/> Neg	

*If required for school entry, must be Mantoux unless exception granted by local health department.

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
 - A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
 - B. If the child has met all immunization requirements, check box A and write in date.
 - C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
 - D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
 - E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must present documentation consistent with Health and Safety Code Section 120365, including documentation of all other required immunizations the child has received. All requirements are met; check box A and box E.*

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____

Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.



INFANT/TODDLER NEEDS AND SERVICE PLAN

Must be updated every 3 months

Child's Name: _____ Date: _____

Feeding

Does your child drink/eat: Breastmilk Formula- _____ Milk- _____

Child now uses: Bottle: How often: _____ Cup: How often: _____

How many ounces per feeding? _____

What is your Child's feeding schedule? _____

Special requirements after feeding? _____

Child is currently on Solid foods? Yes No Child can feed self? Yes No

Does your child use Spoon Fork None

Food likes: _____

Food dislikes: _____

List all food ALLERGIES: _____

Special instructions you would like us to follow regarding your child's eating pattern? _____

Reminder: Bottles and food containers/jars must be labelled with your child's full name and date

Breastmilk bottles must also be labelled with date when milk was expressed.

Medication

Medication(s) taken (including inhaler): _____

How often: _____

ALLERGIES to medication (including latex): _____

Have you completed a parent consent to administer medication: Yes No

Sleeping

Current sleep schedule: _____

Does your child take a nap in the morning? Yes No

Approximately what time? _____

Usually how long?

Does your child take a nap in the afternoon? Yes No

Approximately what time? _____

Usually how long? _____

Does your child use any transitional objects (blankets, pacifier, etc.)?

If yes, what objects? _____

Where does your child sleep? _____

Can you tell us anything about your child's sleeping habits that might be helpful? _____

It is our policy that infants must always be put to sleep on their backs. If children have a medical condition requiring them to sleep in an alternate position, a signed physicians' note is required

Diapering

Child uses:

- Disposable Diapers: Brand- _____
- Cloth Diapers
- Potty Chair
- Toilet
- Wipes: Brand- _____

Are there any specific creams or ointments to be used at diaper changing time? _____

How often? _____

Special Instructions: _____

Our program does not authorize the use of powder products.

A completed Non-Prescription Medical Instruction, Consent and Waiver form on file for the use of all topical ointments (diaper ointments, sunscreen, mosquito repellent etc.) Please note you will need to complete a topical ointment form and update this every 90 days.

Infants and toddlers will be checked frequently and will be kept clean and dry. Parents are to provide diapers and wipes.

Any child without diapers or wipes will be charged \$1 each diaper and \$5 for a pack of wipes.

Potty Training:

At what stage of development does the family anticipate starting the introduction of:

Potty: _____

Underwear: _____

Method of toilet learning:

General Information

Does your child have any special needs? _____

Is there any other information you would like us to know about your child, so we may give them the best possible care? _____

This form is required to be updated each semester as your child's needs change and reviewed with parent/guardian prior to being signed and approved by persons listed below. The family will receive a copy of the updated plan each semester.

Parent/Guardian's Signature

Date

Center Director's Signature

Date

INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: _____

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date
Authorized Representative's Name (Primary Contact)		Phone Number
Authorized Representative's Name (Secondary Contact)		Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in: <input type="checkbox"/> Crib <input type="checkbox"/> Play Yard <input type="checkbox"/> Other (Specify) _____	What are the Infant's usual sleeping hours? _____ _____
What is the infant's average length of the Infant's nap(s) during the day time? _____ minutes _____ hours	Does the infant use a pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If yes , brand: _____

SECTION C: INFANT'S ABILITY TO ROLL

My child, _____ is able to roll from their back to their stomach and stomach to their back beginning _____ / _____ / _____.

Authorized Representative Signature	Date
-------------------------------------	------

SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date
Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? Yes No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature

Date

Your Child is Important to Us



That's why we want to participate in the Child and Adult Care Food Program (CACFP) offered by the United States Department of Agriculture (USDA).

Assistance with meals and snacks that meet the program's nutritional guidelines helps us ensure healthy nutritious meals while also keeping our child care fees as low as possible

How are assistance levels determined?

Assistance levels are based on household income. Additional details about the program are in the Letter to Parents included in this packet.

In order to receive this vital help for meals and snacks, we need you to complete and return the last page front and back (Meal Benefit Form) in this packet.

It only takes a few minutes!

The following information is needed before you begin:

- Names of all children enrolled in the center.
- Case number for CalFresh, CalWORKs, Kin-GAP, or FDPIR benefits, *if applicable*,

OR

- Names and current monthly income (from all sources) for all household members.



Please return the completed Meal Benefit Form ASAP.

If you have any questions about the program or how to complete the form, please contact the child care center director.

Confidentiality of Information on the Meal Benefit Form

We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We will place the MBF in our food program files and keep the information confidential. Only upon your request, will we share the information on your form with officials of other child nutrition, health, and education programs so they can use it to determine benefits for those programs.

Institution Name: Building Better Communities Foundation

Agreement Number: _____

Facility/Provider Name: _____

Child and Adult Care Food Program (CACFP) Participant Enrollment Form

Dear Parent/Guardian,

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female

Date participant enrolled in the facility: _____

Food Allergies: Yes No

If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)Check Days of Normal Care at facility: Sunday Monday Tuesday Wednesday Thursday Friday SaturdayCheck meals normally eaten at facility: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Please list the normal times of arrival and departure (check AM or PM)

Arrive: _____ am pm Depart: _____ am pm

School Times: Depart: _____ am pm Return: _____ am pm

If participant is an infant (0-11 months), please complete this box below. Check all applicable choice(s):

This institution/ facility offers _____ formula for infants through CACFP. It is our choice

(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

- I will use the formula offered by this facility. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.
- I will not use the formula offered by this facility.
If not, which formula will you send for your infant? _____
If the formula you provide is a special formula, a medical statement must be submitted.
- I will provide breastmilk for my infant.
- My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Work Telephone Number: _____ Check Work Shift: 1st 2nd 3rd Other (Specify) _____**For Facility/Provider Use Only:**

Signature of Facility Representative/Provider: _____ Date: _____

Date the Participant Withdrew: _____

Non-Discrimination Statement: This explains what to do if you believe you have been treated unfairly. In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

MEAL BENEFIT FORM FOR CHILDREN
PROGRAM YEAR _____

Name of Child Care Center: _____

Please read the instructions. If you need help completing this form call: (888) 665-4991 _____

Complete, sign, and return form to: Building Better Communities Foundation _____

1. CHILD INFORMATION

(List names of all children enrolled for care)

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

Last	First	M.I.	If all children are foster children, go to #4 and sign this form.
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

2. BENEFITS

If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

CalFresh Case #:
CalWorks Case #:
FDPIR Case #:

3. ALL HOUSEHOLD MEMBERS

Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

Check here if this household receives no income. Go to #4.

NAMES	GROSS INCOME and how often it was received (e.g. weekly, every 2 weeks, twice a month, monthly, or annually)*			
	EARNINGS FROM WORK BEFORE DEDUCTIONS	CHILD SUPPORT ALIMONY	PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY	EARNINGS FROM ANY OTHER INCOME
NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

(PENALTIES FOR MISREPRESENTATION: I Certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	<input type="checkbox"/> Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or FDPIR case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following racial identities:		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	
Please mark one of the following ethnic identities:		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) Fax: 202-690-7442
- (3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

FOR AGENCY USE ONLY	
CATEGORICAL ELIGIBILITY	
CalFresh/CalWORKs/ FDPIR household categorically eligible free ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Foster child automatically eligible free ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
INCOME ELIGIBILITY Annual Conversion: Weekly Times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12	
Total income:	Household size:
Eligibility classification: <input type="checkbox"/> Free <input type="checkbox"/> Reduced Price <input type="checkbox"/> Base	
Determining official (print name):	
Determining Official Signature :	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the Meal Benefit Form to: Building Better Communities Foundation If you need help, call: (888) 665-4991

1. CHILD INFORMATION:

- a) Print your child's name. Print your child's name.
- b) Check box to right of name if a foster child.
- c) Include the name of the child care center.

2. BENEFITS: Complete this section and sign the form in #4.

- a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
- b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. ALL OTHER HOUSEHOLDS: Complete this section and sign the form in #4.

Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**

- a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
- b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

- a) The form must have a **signature** of an adult household member.
- b) The adult household member who signs the statement must include the last four digits of their **SSN**. *If they do not have a SSN, check the box "Check here if no SSN".* The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs or FDPIR case number.

5. RACIAL/ETHNIC IDENTITY: You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT		
<p>Earnings from Work:</p> <ul style="list-style-type: none"> • Wages/salaries/tips • Strike benefits • Unemployment compensation • Worker's compensation • Net income from self-employment <p>Child Support/Alimony</p> <ul style="list-style-type: none"> • Public assistance payments • Alimony/child support payments 	<p>Pensions/Retirement/Social Security</p> <ul style="list-style-type: none"> • Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security 	<p>Other Monthly Income</p> <ul style="list-style-type: none"> • Disability benefits • Cash withdrawn from savings • Interest dividends • Income from estates/trusts/investments • Regular contributions from persons not living in the household • Net royalties/annuities/net rental income • Military allowance for off-base housing • Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native — A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian — A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American — A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander — A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White — A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino — A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino