Holy Rosary Academy & Preschool
2023-2024 Student Emergency Information

Student's Last Name:______________________________ **Ethnicity:** ____________________

Home Address: ____________________________________Home Phone: ________________

City: ____________________________State: __________________Zip: ________________

Name of Parish closest to home address: ____

Mother's Full Name: ______________________________

Employer/Occupation:______________________________Work Phone: ____________________

Work Address: ____________________________________ Mobile Phone: __________________

Father's Full Name: ______________________________

Employer/Occupation:______________________________Work Phone: ____________________

Work Address: ____________________________________ Mobile Phone: __________________

Child's Full Name	Check here if Catholic	Birth Date	Grade for 2023-2024	Allergies/Medications

EMERGENCY CARE INFORMATION - ***IF A PARENT CANNOT BE REACHED, PLEASE CONTACT ANY OF THE FOLLOWING LISTED INDIVIDUALS. THEY ARE AUTHORIZED TO ACT IN OUR ABSENCE, AND WILL BE INFORMED THAT THEIR NAME HAS BEEN USED ON THIS FORM. IN THE EVENT NO ONE CAN BE REACHED, I GIVE HOLY ROSARY ACADEMY & PRESCHOOL PERMISSION TO ACT ON MY BEHALF IN MAKING MEDICAL DECISIONS FOR MY CHILD(REN).***

Name	Relationship to Child	Home Phone	Work Phone

Child's Physician Name:______________________________**Phone:** ____________________

Health Insurance Co:____________________________**Policy #:**__________**Group #:**________

Comments: ____

Current E-Mail address for parent or guardian: ____________________________________

Parent or Guardian Signature:____________________________________**Date:**__________

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

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST MIDDLE FIRST | SEX | TELEPHONE ( )

ADDRESS NUMBER STREET CITY STATE ZIP | BIRTHDATE

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST MIDDLE FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER STREET CITY STATE ZIP | HOME TELEPHONE ( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST MIDDLE FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER STREET CITY STATE ZIP | HOME TELEPHONE ( )

PERSON RESPONSIBLE FOR CHILD LAST NAME MIDDLE FIRST | HOME TELEPHONE ( ) | BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: ____________________

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

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

DATE OF ADMISSION | DATE LEFT

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

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

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

IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* MONTHS | BEGAN TALKING AT* MONTHS | TOILET TRAINING STARTED AT* MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO | HOW MANY IN LAST YEAR? | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?*

DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST ______
LUNCH ______
DINNER

ANY FOOD DISLIKES? | ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS:

DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE | DATE

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Children's Residential Facilities

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

______________________________ TO PROVIDE 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 WHATEVER
NAME

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 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: 3737 Main Street, Suite 700 Riverside, CA 92501

   Licensing Office Telephone #: (951) 782-4200

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
Community Care Licensing

ADDRESS
3737 Man Street, Suite 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside	92501	(951) 782-4200

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)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

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

____________________ (NAME OF CHILD), born ____________________ (BIRTH DATE) is being studied for readiness to enter ____________________ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from ____ : ____ a.m./p.m. to ______ a.m./p.m., __________ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

____________________ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) ____________ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: | Allergies: medicine:

Vision: | Insect stings:

Developmental: | Food:

Language/Speech: | Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: ____________________ Date of Physical Exam: ____________________
Address: ____________________ Date This Form Completed: ____________________
Telephone: ____________________ Signature ____________________

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

Getting to Know You!

You know your child best! Share with me some information to help me get to know your child.

Child's Name:________________ Nickname: ________________

What are your child's favorite activities/things?

____

What are your child's favorite strengths?

____

What goals do you have for your child?

____

Is this your child's first school experience? Yes No

Does your child separate easily from you? Yes No

Does your child have any fears?
Yes:______________ No

How would you describe him/her?

____

____

Other information I should know"

____

____

My Family

List the names of family members who live in your house.

Parents	
Siblings (age too)	
Pets	
Other Family Members	

POCKET OF PRESCHOOL

Our class is using ClassDojo!

¡Nuestra clase está usando ClassDojo!

Hi parents,

This year I'm using ClassDojo to encourage important skills like working hard and participating. I'll also use it to communicate with you: we can instantly share messages, updates and photos from class. It's the easiest way for you to see how your child is doing at school every day and to get in touch with me.

I'd like all families to join me and sign up for ClassDojo! You can use it on any device: it is a **simple, free mobile app** for iOS and Android, and can also be used from a computer at: www.classdojo.com

I will need your cell number or email to invite you to ClassDojo. Our class goal is for every family to **fill out and return the slip below by tomorrow!** Feel free to ask me any questions.

Thank you so much!

Hola padres de familia,

Este año estoy usando ClassDojo para fomentar habilidades importantes, como el trabajo duro y la participación. También lo voy a usar para comunicarme con ustedes: podemos compartir al instante mensajes, actualizaciones y fotos de la clase. Es la manera más fácil para que ustedes puedan ver cómo está su hijo en la escuela y se pongan en contacto conmigo.

¡Me gustaría que todas las familias se unieran a mí y se registraran en ClassDojo! Se puede utilizar en cualquier dispositivo: es **una aplicación móvil sencilla**, gratis para iOS y Android, y también se puede utilizar desde una computadora en: www.classdojo.com.

Voy a necesitar su número de celular o correo electrónico para invitarlos a ClassDojo. Nuestro objetivo de clase es que todas las familias **llenen y devuelvan la información de abajo para mañana.** No duden en hacer cualquier pregunta.

¡Muchas gracias!

Please send me my invitation to ClassDojo

Por favor, envíenme mi invitación para ClassDojo

Student's name:
Nombre del estudiante ____________________

Parent's name:
Su nombre ____________________

Your cell number **OR** email:
Su celular o email ____________________

Want to find out more? Visit www.classdojo.com/**LearnMore**

¿Quiere saber más? Visite www.classdojo.com/**LearnMore**