Thank you for your interest in the Mtn.View Preschool Program offered through Claremont Unified School District. Please review the list of **REQUIRED** documentation and begin to gather **ALL the documentation that applies**. Once you have all the documentation, please give me a call to schedule an enrollment appointment. Please be advised that failure to have the necessary documentation at the enrollment appointment will require you to reschedule until all documentation can be provided. Preschool slots are filled on a first come, first-served basis. If you have questions regarding any of the documentation listed below, please feel free to give me a call. Thank you.

Ruby Garcia, Preschool Account Clerk (909) 399-1713 or e-mail: rgarcia@cusd.claremont.edu

**DOCUMENTATION REQUIRED FOR ENROLLMENT**

- **One of the following**
  1. Birth certificate or hospital birth record
  2. Record of foster care placement
  3. Adoption documents
  4. Court order regarding child custody

- **Proof of residency** (Documentation of residency dated from the last 30 days except a cell phone bill; **CELL PHONE bills are not acceptable**)

- **Guardianship and Foster Care Documentation** (for Foster Parents or Legal Guardians)
  1. Foster care placement records
  2. Guardianship documents
  3. Foster Care Grants, payments or clothing allowances for the child and related siblings
  4. Other financial assistance received for the child.

- **Current Physical Exam and TB test results for each enrolling child** (form included in Registration Packet)
  1. Physical must have been done within the last year.
  2. Physical form must be completed and stamped by Doctor’s office (form is attached)

- **Proof of the following immunizations for parent volunteers or other authorized adult**
  1. TB skin test- must be dated within the last year.
  2. If tested positive for TB, must bring in Chest X-Ray results dated within the last three (3) years
  3. DTaP (whooping cough)
  4. INFV (influenza)

- **Immunization Record for each child enrolling**
  1. Children must be current on all immunizations in order to enroll.
     - 3-Polio
     - 4-DTP/DTaP/DT/Td
     - 1-MMR
     - 4-HIB
     - 3- HepB
     - 1- Varicella
     - TB Test Results
- **Registration Packet**
  1. All forms in packet must be completed in full.

- **Registration fees:** $75.00 (cash, check)

- **Monthly Tuition fee:** $555.66

(Cash, Check, Credit Card, Debit Card) please note Credit and Debit transactions will only be available online.
**CLAREMONT UNIFIED SCHOOL DISTRICT**
**PRESCHOOL PROGRAM REGISTRATION FORM**

<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
<th>ETHNICITY (SELECT ONE)</th>
<th>RACE</th>
<th>BIRTHDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ HISPANIC OR LATINO</td>
<td>□ Boy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ NOT HISPANIC OR</td>
<td>□ Girl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LATINO</td>
<td>□ Boy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ HISPANIC OR LATINO</td>
<td>□ Girl</td>
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</tr>
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<td></td>
<td>□ NOT HISPANIC OR</td>
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<td></td>
<td>LATINO</td>
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<tr>
<th>(Last)</th>
<th>(First)</th>
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</table>

<table>
<thead>
<tr>
<th>PARENT:A/GUARDIAN</th>
<th>PARENT:B/GUARDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>(City / Zip)</td>
<td>(City / Zip)</td>
</tr>
<tr>
<td>Home phone:</td>
<td>Home phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>E-Mail Address:</td>
<td>E-Mail Address:</td>
</tr>
<tr>
<td>Employer:</td>
<td>Employer:</td>
</tr>
<tr>
<td>Work Address:</td>
<td>Work Address:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
</tr>
</tbody>
</table>

Parent’s Marital Status: ________________________________

With whom does the child live? __________________________

Primary language spoken at home by Parents: ____________

by Child(ren): ____________

Would you consider your child to be fluent in the English language? □ No □ Yes

**Will your child need to take medication during preschool hours?** □ No □ Yes

If Yes, list medication, dosage & time.

Medication: __________________________

Dosage: __________________________

Time: __________________________

The following is also required:

1) Prescription for the Medication [medication must be in original container]
2) Signed Medication Authorization Form.

**CHILD’S PHYSICIAN:** __________________________

**PHONE:** __________________________

Does your child have a disability, physical limitation, medical condition, allergy, etc.? □ No □ Yes

If yes, please list: __________________________

List specific instructions for care in the event of an emergency concerning the above:

________________________________________________________________________

Please Complete Other Side ➔
Does your child have an Individualized Education Plan (IEP) □ No □ Yes; if yes, please provide us with a copy of the IEP.

Do you give consent for your child/children to participate in the celebration of birthdays, cultural holidays, and traditions? □ Yes □ No
Initial  

Do you give your consent to Claremont Unified School District staff to take photographs and/or videos of your child/children during regular program activities to be used as a part of your child’s portfolio or activity in the classroom? □ Yes □ No
Initial  

Do you give consent to Claremont Unified School District to take photographs and/or videos of your child/children during regular program activities to be used as part of our program outreach activities that may include displays, advertising, program brochure, parent handbook, and/or Claremont Unified School Districts website? □ Yes □ No
Initial  

**IN CASE OF AN EMERGENCY, WE WILL MAKE EVERY EFFORT TO CONTACT THE PARENTS/GUARDIANS. HOWEVER, WE ASK THAT THREE NEARBY ADULTS (18 YEARS OR OLDER) BE LISTED AS ALTERNATE CONTACT PERSONS WHO ARE HEREBY AUTHORIZED TO PICK UP THE CHILD FROM THE PROGRAM, AND/OR ASSIST US IN REACHING YOU, IN THE EVENT OF AN EMERGENCY.**

Your child will not be allowed to leave the program with any other person without advance written authorization from the child’s parent or guardian. **Photo identification is required. Any changes to the people listed below must be done in writing. Telephone and email authorizations are not allowed.**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS / CITY / STATE / ZIP</th>
<th>TELEPHONE</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

I, as the parent/guardian of the child/children listed on this application, hereby give consent to Claremont Unified School District and its Preschool staff to obtain all emergency medical or dental care prescribed by a duly licensed Physician (M.D.) Osteopath (D.O.) or Dentist (D.D.S). This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my child/children. I understand that the Preschool staff may, if possible, attempt to contact me or other individuals whom I have designated in the event of an emergency. I hereby further give consent to the Preschool staff to call for emergency assistance for my child/children, arrange for transporting my child/children to an emergency center, and take such other actions that Preschool staff determine reasonable or necessary under the circumstances. I understand and agree that I will be responsible for all costs and expenses incurred in connection with treatment and/or transportation of my child/children, and that the Preschool staff and the Claremont Unified School District shall not be financially responsible for any expenses.

Parent/Guardian Signature:  

**BY COURT ORDER, THIS CHILD MAY NOT BE LEGALLY RELEASED INTO THE CUSTODY OF:**  

________________________________. (We must have a copy of the most recent court order for our file.)

THE UNDERSIGNED HEREBY CERTIFIES THAT THE INFORMATION PROVIDED IN THIS REGISTRATION FORM IS TRUE AND CORRECT AND FURTHER ACKNOWLEDGES AND AGREES TO THE TERMS HEREBIN.

Parent's Signature:  

Date:  

Revised June 2019
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 Division Monterey Park Regional Office

   Licensing Office Address: 1000 Corporate Center Dr, Monterey Park, CA 91754

   Licensing Office Telephone #: (323)981-3350

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

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
NOTIFICACIÓN SOBRE LOS DERECHOS DE LOS PADRES
EN RELACIÓN A LAS GUARDERÍAS INFANTILES

DERECHOS DE LOS PADRES

Como padre/madre/representante autorizado, usted tiene derecho a:

1. Entrar e inspeccionar la guardería infantil (llamada “guardería” de aquí en adelante) sin notificación previa, en cualquier momento en el cual los niños estén bajo cuidado.

2. Presentar una queja con la oficina de licenciamiento en contra de la persona con licencia y revisar el expediente público que la oficina de licenciamiento tenga de la persona con licencia.

3. Revisar, en la guardería, los reportes sobre las visitas a la guardería por parte de la oficina de licenciamiento y las quejas comprobadas en contra de la persona con licencia que se hayan presentado durante los últimos tres años.

4. Quejarse con la oficina de licenciamiento e inspeccionar la guardería sin que se discrimine ni que se tomen represalias en contra de usted ni de su hijo.

5. Pedir por escrito que no se le permita a un padre/madre que visite al niño de usted ni que se le lleve de la guardería, siempre y cuando usted haya presentado una copia certificada de la orden de la corte.

6. Recibir de la persona con licencia el nombre, dirección y número de teléfono de la oficina local de licenciamiento.

<table>
<thead>
<tr>
<th>Nombre de la oficina de licenciamiento:</th>
<th>Community Care Licensing Division Monterey Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección de la oficina de licenciamiento:</td>
<td>1000 Corporate Center Drive, Suite 200B</td>
</tr>
<tr>
<td>Número de teléfono de la oficina de licenciamiento:</td>
<td>(323) 981-3350</td>
</tr>
</tbody>
</table>

7. Después de haberlo solicitado, que la persona con licencia le informe del nombre y tipo de asociación con la guardería de cualquier persona adulta a quien se le haya otorgado una exención en relación a sus antecedentes penales, y que el nombre de la persona también se puede obtener comunicándose con la oficina local de licenciamiento.

8. Recibir de la persona con licencia, el formulario sobre el proceso para la revisión de los antecedentes de los proveedores de cuidado.

NOTA: LA LEY ESTATAL DE CALIFORNIA ESTIPULA QUE LA PERSONA CON LICENCIA PUEDE NEGAR EL ACCESO A LA GUARDERÍA AL PADRE/MADRE/REPRESENTANTE AUTORIZADO SI SU COMPORTAMIENTO PONE EN RIESGO A LOS NIÑOS BAJO CUIDADO.

Para ver la base de datos del Departamento de Justicia sobre los delincuentes sexuales inscritos (conocida en inglés como “Registered Sex Offender Database”), vaya a www.meganslaw.ca.gov

CONFIRMACIÓN DE HABER RECIBIDO LA NOTIFICACIÓN
SOBRE LOS DERECHOS DE LOS PADRES
(Se requiere la firma del padre/madre/representante autorizado.)

Yo, el padre/madre/representante autorizado de _________________, he recibido, de la persona con licencia, una copia de la “NOTIFICACIÓN SOBRE LOS DERECHOS DE LOS PADRES EN RELACIÓN A LAS GUARDERÍAS INFANTILES” y el formulario sobre el PROCESO PARA LA REVISIÓN DE LOS ANTECEDENTES DE LOS PROVEEDORES DE CUIDADO.

Nombre de la guardería

Firma (Padre/madre/representante autorizado) ____________________________
Fecha ____________________________

NOTA: Esta Confirmación se tiene que conservar en el expediente del niño y una copia de la Notificación se le tiene que dar al padre/madre/representante autorizado.

Para ver la base de datos del Departamento de Justicia sobre los delincuentes sexuales inscritos (conocida en inglés como “Registered Sex Offender Database”), vaya a www.meganslaw.ca.gov
PERSONAL RIGHTS
Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.
(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

Department of Social Services

NAME
Community Care Licensing Division Monterey Park Regional Office

ADDRESS
1000 Corporate Center Drive, Suite 200B

CITY Monterey Park

ZIP CODE 91754

AREA CODE/TELEPHONE NUMBER (323) 981-3350

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: 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)

LIC 613A (6/08)
DERECHOS PERSONALES

Guarderías infantiles

Derechos personales - Vea la Sección 101223 sobre las condiciones para exenciones en relación a las guarderías infantiles.

(a) Guarderías infantiles. Cada niño que reciba servicios de una guardería infantil tendrá derechos que incluyen pero que no se limitan a los siguientes:

1. a ser tratado con dignidad en sus relaciones personales con el personal del establecimiento y con otras personas.

2. a que se le proporcione alojamiento, muebles, y equipo que sean seguros, higiénicos, y cómodos, para satisfacer sus necesidades.

3. a no recibir castigo corporal o poco común; a que no se le cause dolor o humillación; a que no se le intimide; a no recibir burlas, coerción, amenazas, abuso mental, u otros castigos incluyendo pero no limitándose a: interferir con las funciones diarias de la vida, tales como el comer, dormir, o usar el baño; a que no se le niegue alojamiento, ropa, medicamentos, o medios auxiliares para el funcionamiento físico.

4. a que la persona con licencia para el cuidado de niños le informe al niño, así como a su representante autorizado si lo hay, sobre lo que dice la ley con respecto a las quejas. Esta información debe incluir pero no limitarse a la dirección y número de teléfono de la sección en la oficina de licenciariado que recibe quejas, a información con respecto a la confidencialidad.

5. a tener la libertad de asistir a los servicios o a las actividades religiosas que desee, y a recibir visitas del consejero espiritual que prefiera. La asistencia a los servicios religiosos, ya sea dentro o fuera del establecimiento, deberá ser completamente voluntaria. En las guarderías infantiles, los padres o tutores legales del niño deberán tomar las decisiones sobre la asistencia a servicios religiosos y las visitas de consejeros espirituales.

6. a que no se le encierre con llave en ninguna habitación, edificio, ni parte del establecimiento durante el día o la noche.

7. a que no se le coloque en ningún aparato para limitar sus movimientos, excepto en un aparato de restricción para proporcionar apoyo que haya sido aprobado desde antes por la oficina de licenciamiento.

EL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL TIENE EL DERECHO A QUE SE LE INFORME SOBRE LA OFICINA DE LICENCIAMIENTO APROPIADA CON LA CUAL DEBE COMUNICARSE SI TIENE QUEJAS. LA OFICINA ES:

Department of Social Services

NOMBRE

Community Care Licensing Division Monterey Park Regional Office

DIRECCIÓN

1000 Corporate Center Drive, Suite 200B

CUIDAD

Monterey Park

CÓDIGO POSTAL

91754

AREA/NÚMERO DE TELÉFONO

(323) 981-3350

AL: PADRE/MADRE/TUTOR LEGAL/NIÑO O REPRESENTANTE AUTORIZADO:

Confirme la siguiente información, una vez que se le haya dado la información respecto a los derechos personales de una manera satisfactoria y completa, según se explica aquí:

CONFIRMACIÓN: Se me (nos) informó personalmente y recibí una copia de los derechos personales que contiene el Título 22 del Código de Ordenamientos de California, en el momento de admisión a:

(FIRMA DEL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL)

(TÍTULO/PUESTO DEL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL)
# 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 Child Been Under Regular Supervision of Physician?**

**Date of Last Physical/Medical Examination**

## Developmental History

<table>
<thead>
<tr>
<th>Walked At</th>
<th>Months</th>
<th>Began Talking At</th>
<th>Months</th>
<th>Toilet Training Started At</th>
<th>Months</th>
</tr>
</thead>
</table>

## Past Illnesses — Check illnesses that child has had and specify approximate dates of illnesses:

- [ ] Chicken Pox
- [ ] Asthma
- [ ] Rheumatic Fever
- [ ] Hay Fever
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Whooping Cough
- [ ] Mumps
- [ ] Poliomyelitis
- [ ] Ten-Day Measles (Rubeola)
- [ ] Three-Day Measles (Rubella)

**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 Set Up?**

**What Time Does Child Go To Bed?**

**Does Child Sleep Well?**

**Does Child Sleep During the Day?**

**When?**

**How Long?**

**Diet Pattern:**

- Breakfast
- Lunch
- Dinner

**What Does Child Usually Eat for These Meals?**

**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"**

**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/Pears/Needs? (Explain)**

**What is the Plan for Care When the Child is Ill?**

**Reason for Requesting Day Care Placement**

**Parent's Signature**

**Date**

__

**Lic 702 (8/98) (Confidential)
| ENFERMEDADES EN EL PASADO — Marque las enfermedades que el niño ha tenido y especifique las fechas aproximadas de las mismas: |
|-----------------------------------------|------------------|------------------|------------------|
| Varicela                                | Diabetes         | Poliomielitis    |
| Asma                                    | Epilepsia        | Sarampión de diez días (Rubeola) |
| Fiebre reumática                        | Tos ferina       | Sarampión de tres días (Rubella) |
| Fiebre del heno                         | Paperas          |                  |

| ESPECIFIQUE OTRAS ENFERMEDADES O ACCIDENTES SERIOS O GRAVES |

| ¿Tiene el niño resfriados frecuentes? | Sí | No | ¿Cuántos en los últimos doce meses? | ANOTE CUALQUIER ALERGIA DE LA CUAL EL PERSONAL DEBE ESTAR ENTERADO |

| RUTINA DIARIA — (sólomente para los bebés y niños de edad preescolar) |
|--------------------------|------------------|------------------|
| La hora que se levanta el niño? |
| La hora que se acuesta el niño? |
| ¿Duerme bien el niño? |
| ¿Duerme el niño durante el día? |
| Cuando? |
| Por cuánto tiempo? |

| PATRÓN DE DIETA: |
|-----------------|------------------|------------------|
| Desayuno        |
| (¿Qué come el niño usualmente para estas comidas?) |
| Almuerzo |
| Cena |

| ¿Hay algunos alimentos que no le gustan comer? | ¿Tiene algún problema de alimentación? |

| ¿Babe el niño como ir al baño? |
| Si | No |
| Siesta | ¿En qué época de aprendizaje está? |
| Si | No |
| ¿Tiene evacuaciones intestinales regulares? |
| Si | No |
| ¿Cuál es la hora usual? |

| ¿Cual es la palabra que se usa para designar las evacuaciones intestinales? |
| ¿Cuál es la palabra que se usa para designar la descarga de la orina? |

| EVALUACIÓN DE LA SALUD DEL NIÑO POR PARTE DEL PADRE/MADRE |

| ¿Está el niño actualmente bajo el cuidado de un doctor? |
| Si | No |
| Si | Conozca el nombre del doctor: |
| ¿Está tomando el niño medicamentos recetados? |
| Si | No |
| ¿Ha usado el niño algún aparato especial? |
| Si | No |
| Si | Conozca la clase y efectos secundarios: |
| ¿Usa el niño algún aparato especial en su casa? |
| Si | No |

| EVALUACIÓN DE LA PERSONALIDAD DEL NIÑO POR PARTE DEL PADRE/MADRE |

| Firma del padre/madre |

| LIC 792 (SP) (7199) (CONFIDENTIAL) |

| LIC 792 (SP) (7199) (CONFIDENTIAL) |

| LIC 792 (SP) (7199) (CONFIDENTIAL) |
PART A – PARENT’S CONSENT (TO BE COMPLETED BY PARENT)

________________________, born ____________________________ is being studied for readiness to enter _____________________________. 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.)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLIO (OPV OR IPV)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>DTP/DTaP/DTTtd (DIPHTHERIA, TETANUS AND ACELULAR TETANUS)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>MMR (MEASLES, MUMPS, AND RUBELLA)</td>
<td>/</td>
<td>/</td>
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<td>/</td>
<td></td>
</tr>
<tr>
<td>HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>VARICELLA (CHICKENPOX)</td>
<td>/</td>
<td>/</td>
<td>/</td>
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<td>/</td>
</tr>
</tbody>
</table>

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

LIC 701 (8/06) (Confidential) PAGE 1 OF 2
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.
# Identification and Emergency Information

**Child Care Centers/Family Child Care Homes**

To Be Completed by Parent or Authorized Representative

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST</th>
<th>MIDDLE</th>
<th>FIRST</th>
<th>SEX</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
<td></td>
</tr>
<tr>
<td>HOME ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
<td></td>
</tr>
<tr>
<td>PERSON RESPONSIBLE FOR CHILD</td>
<td>LAST NAME</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>HOME TELEPHONE</td>
<td>BUSINESS TELEPHONE</td>
</tr>
</tbody>
</table>

## Additional Persons Who May Be Called in an Emergency

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
</table>

## Physician or Dentist to Be Called in an Emergency

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>ADDRESS</th>
<th>MEDICAL PLAN AND NUMBER</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTIST</td>
<td>ADDRESS</td>
<td>MEDICAL PLAN AND NUMBER</td>
<td>TELEPHONE</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
</table>

## 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

LC 700 (6/06)(CONFIDENTIAL)
Mt. View Preschool
Admissions Agreement

Read each statement below and initial on each line that you understand and agree to abide by these rules while you are receiving services from the Preschool Program.

1. I understand that all the statements and information provided to the Child Development office must be true and correct.

2. I will take my child to the site according to contracted hours and will make arrangements to have my child picked up if I cannot make it on time.

3. I understand that for my child to participate in, and derive full benefit of the educational program provided by the CUSD Preschool program, my child is expected to be there on time every day.

4. I understand that excessive late pick-ups may result in termination from the Preschool program.

5. I understand that my child must be signed in upon arrival with the exact time and signed out upon departure with the exact time. I understand the person signing out must be 18 years of age or older and must use a FULL and legible signature.

6. I must call the site if my child will be absent due to illness, medical appointment, or vacation.

7. I must notify the Child Development office of any changes including, but not limited to, my address, telephone number, work number, and emergency contacts.

8. I will not send my child to school with a communicable disease. If my child becomes ill while in school, I or another adult listed on the emergency card will pick-up my child within one (1) hour of being called.

9. I understand that my child will not be released to any person not listed on the authorized persons list. I further understand that changes to the people listed on the authorized list must be made in person, and in writing.

10. I understand that if I wish to volunteer in my child’s Preschool classroom, I must have a current TB test dated with the last year (for skin test) OR the last four (4) years for Chest X-Ray.

I have read, understand and agree to the above responsibilities as a parent/guardian enrolling in the CUSD Preschool program. I also understand that failure to abide by these responsibilities may be grounds for termination of my preschool services.

Parent/Guardian Name (Print)  Parent/Guardian Signature  Date

Child’s Name  CDP Clerk Initials