STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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
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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)

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

La Cristianita Preschool . 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: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

La Cristianita Preschool 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'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*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

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

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

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

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

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

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

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

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?

BREAKFAST _____

LUNCH _____

DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'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

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

Department of Social Services

ADDRESS

750 The City Drive; Suite 250

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Orange	92668	(714) 703-2800

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)
La Cristianita Preschool	35522 Camino Capistrano, San Clemente, Ca 926

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(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: Department of Social Services

   Licensing Office Address: 750 The City Drive; Suite 250 Orange, Ca 92668

   Licensing Office Telephone #: (714) 703-2800

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.

La Cristianita Preschool
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

ADMISSION AGREEMENT

I have read, understand, and will comply with the policies set forth by LA CRISTIANITA PRESCHOOL. I also understand that the registration fee paid upon registering my child is non refundable. Any changes I wish to make after registering will be subject to availability.

My child will attend _____ Days per week at $_____ per month, playable in advance.

Signature of Parent/Guardian _____ Date_____

Signature of Facility Representative_____ Date_____

SUNSCREEN PERMISSION

I give permission for the La Cristianita Preschool staff to apply a sunscreen product fo SPF15 or higher to my child, as specified below, when he or she will be engaged in outdoor activities. I understand that sunscreen will primarily used during the months of June, July, and August and between the hours of 10:00am to 4:00pm and will be applied to exposed skin (including, but not limited to the face, tops of ears, nose, bare shoulders, arms, and legs).

Additionally, I have checked and/or indicated below my directions regarding the type and application of sunscreen:

_____ The staff of La Cristianita Preschool may use the sunscreen of their choice, in keeping with the federal and state standards, except the following (if specified): _____
_____

_____ Use only the sunscreen I have provided for my child.

_____ For medical or other reasons, please don't apply sunscreen to my child.

Child's Name _____

Parent's Signature _____ Date _____

La Cristianita Preschool Release Form

I, _____, the parent/guardian of

_____, a student at La Cristianita Preschool, Christ Lutheran Church, 35522 Camino Capistrano, San Clemente, Ca, for good and valuable consideration release and hold harmless said school and church staff, its employees and agents, from any and all liability as a result of sickness or accident on campus, or during any excursion. I will be responsible for any expense due to medical attention rendered. I understand the school's agents will attempt to locate me, or other persons listed on my forms, in the event of sickness or accident.

I hereby grant permission for my child to use all the play equipment and participate in all of the activities of the school.

I hereby grant permission for my child to participate in off campus neighborhood walks.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care for my child if warranted.

I understand this release is valid the entire time my child is enrolled in the school.

SPECIAL INSTRUCTIONS:

Physician's Name _____ **Phone #**_____

Signature of Parent/Legal Guardian_____

Phone # _____ **Cell #** _____

Disaster Procedure/ Emergency Information Form

Please read and fill out the requested information. Return the bottom portion of this paper to your child's teacher. Thank you.

Procedures:

What we will do:

In the event of an emergency all children will be kept on the premises and supervised by staff until parents or designated persons can safely pick the children up. The school has sufficient supplies to care for your child and has made arrangements with local grocery stores for priority treatment in the event of extended emergency situations.

What you should do:

PLEASE DO NOT CALL THE SCHOOL. Lines must remain open for emergency personnel only. Pick your child up as soon as it is safely possible. (follow instructions given by official radio and TV information channels.)

PLEASE SIGN AND FILL OUT INFORMATION REQUESTED BELOW:

I have received the disaster plan information sheet:

Parent's name:_____ Date:_____

Child's name:_____

In the event of an earthquake or other disaster emergency, the following people are authorized to take my child from school premises:

Name_____ Relationship_____

Name_____ Relationship_____

Emergency Phone Numbers:

Parent's_____

Alternates: (please include one out of state contact)

Name_____ Phone #_____

Name_____ Phone #_____

Special Instructions or Medical Conditions to be noted (use back of form if needed:

_____

_____

_____

_____

Classroom Phone Directory

We have had several parents request home phone numbers. Occasionally these numbers are helpful for birthday party invitation information, change of plans or simply to invite a friend over to play. The State does no permit us to release personal information from our files without your consent.

Please complete the following information and check the appropriate boxes.

Child's name_____Phone #_____

Teacher:_____

Days/ Time attending: __Monday __Tuesday __Wednesday __Thursday
__Friday __AM-half __PM-half __Full

I agree that the personal informationin the directory may not be duplicated, given away, or sold to anyone else, but is intended for and restricted to personal use by preschool families.

_____ **Yes**, Please print my child's name and phone number in the class phone list.

_____ **No**, DO NOT PRINT my child's information in the class phone list.

Parent's Signature_____Date_____

Preschool Child Roster

The State Department of Social Services requires that the preschool maintain a complete roster with the following information on each child being provided care in the facility.

Please complete the following information.

Child's name_____Birth date_____

Address_____

Parent/ Guardian name_____Daytime phone # _____

Parent/ Guardian name_____Daytime phone #_____

Physician's name_____Phone #_____

Date enrolled_____

For Office Use ONLY
Date LEFT_____

EMERGENCY CARD

Child's Name _____ Birthdate _____
Parent's Name _____ Work Phone (___)_____
Address _____ City _____ Zip _____
Home Phone (___)_____ Cell Phone (___)_____
Parent's Name _____ Work Phone (___)_____
Address _____ City _____ Zip _____
Home Phone (___)_____ Cell Phone (___)_____

MUST LIST PERSONS AUTHORIZED TO PICK UP CHILD OTHER THAN PARENTS:

Name _____ Phone (___)_____
Address _____
Name _____ Phone (___)_____
Address _____

CONSENT FOR MEDICAL TREATMENT:

As the parent, agency representative or legal guardian, I hereby give consent to La Cristianita Preschool to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.), osteopath (D.O.) or dentist (D.D.S.) for

_____. This care may be given
(Name)
under whatever conditions are necessary to preserve life, limb or well being of my dependent.

CHILD HAS THE FOLLOWING ALLERGIES:

_____ _____
(Parent/Agency representative/Guardian Signature) (Date)

Physician's Name _____ Phone# (___)_____

Office Use Only W/D Date ___/___/___

EMERGENCY CARD

Child's Name _____ Birthdate _____
Parent's Name _____ Work Phone (___)_____
Address _____ City _____ Zip _____
Home Phone (___)_____ Cell Phone (___)_____
Parent's Name _____ Work Phone (___)_____
Address _____ City _____ Zip _____
Home Phone (___)_____ Cell Phone (___)_____

MUST LIST PERSONS AUTHORIZED TO PICK UP CHILD OTHER THAN PARENTS:

Name _____ Phone (___)_____
Address _____
Name _____ Phone (___)_____
Address _____

CONSENT FOR MEDICAL TREATMENT:

As the parent, agency representative or legal guardian, I hereby give consent to La Cristianita Preschool to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.), osteopath (D.O.) or dentist (D.D.S.) for

_____. This care may be given
(Name)
under whatever conditions are necessary to preserve life, limb or well being of my dependent.

CHILD HAS THE FOLLOWING ALLERGIES:

_____ _____
(Parent/Agency representative/Guardian Signature) (Date)

Physician's Name _____ Phone# (___)_____

Office Use Only W/D Date ___/___/___