Things to bring
And
Important Information

1. All paperwork including shot card must be completed before 1st day except physician's report. That MUST be in by the end of the 2nd week of attendance.
2. Download the remind App:
   *Class code @26cadf *Sign up account under child's first and last name not parents. If more than 1 child put both children's first names no last.
   *Put account as a parent account. If you put it as a child's account, we cannot message you.
   *Make sure you turn on notifications and replies.
   THIS IS HOW WE SEND ALL FLYERS AND IMPORTANT NOTIFICATONS.
   VERY IMPORTANT TO SIGN UP.

INFANTS NEED
Crib sheet, receiving blanket, if on bottles, Formula, Milk, Juice for the day-Name and date on bottle, name on lid, change of clothes folded in a labeled gallon sized zip lock bag (to be left at school), Food (Names and date on all food) Lunch included once 12 months, Pack of diapers, wipes, diaper cream (if used)

TODDLERS NEED
Crib sheet and blanket, change of clothes folded in a labeled gallon sized zip lock bag (to be left at school), Pack of diapers, wipes, diaper cream (if used), Spill proof sippy cups with milk, juice water for the day.

PRESCHOOL NEEDs
Crib sheet and blanket, change of clothes folded in a labeled gallon sized zip lock bag (to be left at school), Pack of pull ups, wipes (if not potty trained)
Spill proof cup with WATER ONLY. Milk will be proved with meals.

PLEASE LABEL EVERYTHING

CHECK LIST Please check off as completed.

1. _____Identification sheet (2 Copies)
2. _____ Physician's report.
3. _____ Preadmission Health History
4. _____ Tuition/Admission Agreement
5. _____ Family Information form
6. _____ Personal Rights
7. _____ Parents Rights
8. _____ Consent forms & Directory
9. _____ Medical Treatment
10. _____ Infant needs (0-18 months only)
11. _____ Meal benefit form (ALL children)
12. _____ Sign up for Remind.
    instructions above.
13. _____ shot record

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

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

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

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:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ 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.

Stepping Stones Learning Center
Tuition/Admission Agreement

Child's Name _____

The tuition rate/option I choose is:
____Weekly $_____ Due every Friday for the following week. A late fee of $10.00 needs to be added after 6PM on Fridays and $20.00 needs to be added after 6 pm on Tuesdays. They will not be allowed to attend if no payment is made by Wednesday.

____Monthly $_____ Due on or before the 1st of the month. If the 1st is on a weekend it is due the Friday before. A late fee of $20.00 needs to be added on the 2nd. They will not be able to attend on the 4th if no payment is made.

Full payment is due at enrollment for the option you are choosing. The next month/week will be prorated and due on the next Friday or the 1st of the next month.

At the time of registration, two week tuition is due as a deposit. The deposit is non refundable. The deposit will be used the first two weeks of attendance.

Because our program and licensing regulations require us to schedule staff based on the number of children enrolled, we can NOT give tuition refunds/credits for days your child is absent or for scheduled holidays. If you are on the monthly plan and leave before the month is over a refund for unused days will not be given since it is prorated on a monthly basis.

TWO WEEKS WRITTEN NOTICE IS REQUIRED TO WITHDRAW FROM THE PROGRAM.

ALL CHILDREN MUST BE AT SCHOOL BY 9:30 OR CALLED BY 9:30 TO LET US KNOW YOU WILL BE IN LATE, OR THEY CAN NOT STAY. FOR RATIO PURPOSE.

Tuition charges are subject to change. In such case, you will receive a 30 day notice.

Circle the following:
Days my child will need care are Mon. Tues. Wed. Thurs. Fri.
The normal hours they will attend are: _____ A.M. to _____P.M.
My child will usually have Circle: Breakfast, Lunch, snack which at school.

My child has permission to use all play equipment and participate in all school activities. The school has my permission to use pictures of my child on social media (Facebook, website, remind, etc.). My child (2years and up) may leave the school for field trips with parents' prior authorization.

This agreement is entered into in compliance with the California State Department of Social services. The Department of Social Services reserves the right to enter the school at any time and also interview students, teachers, and parents when needed.

By signing this page, I am Stating that I have read and understand the Tuition/Admission agreement and operating policies (parent Handbook-online at steppingstonesoc.com) and agree to their terms and conditions.

_____ _____
Parent Signature Date

Stepping Stones Learning Center

Family Information Form

ALL areas MUST be filled out.

For accounting and collection purposes.

Child's Name _____

Mother's Name _____ Father's Name _____

Mother's Birthdate _____Father's Birthdate _____

Mother's SSN_____Father's SSN_____

Mother's DL# _____Father's DL# _____

Parents: Married _____ Divorced_____

Living together _____ Living Separate _____

Names and ages of siblings

_____ age _____

_____ age_____

_____ age_____

Father's Occupation _____

Employer _____

Address _____

Phone _____

Work Hours _____

Mother's Occupation _____

Employer _____

Address _____

Phone _____

Work Hours _____

How did you hear about Stepping Stones? _____

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

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)

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

Parent Consent for Toddler-Option Program

We have an infant program that goes from 6 weeks to 24 months. You have the option to move your child to the toddler program at 18 months if you choose. The toddler program goes from 18 months to 36 months. At age 2 they can move to the preschool program if they are ready.

_____I would like my child to start transitioning to the toddler program at 18months. (As long as he/she is ready).

_____I would not like my child to transition to the toddler program. I want them to stay in the infant program until age 2 then go straight to the preschool program.

I understand that this is voluntary and my own choice, and the DSS requires that I sign my consent to such placement.

_____ _____

Parent Signature Date

Parent Consent To Preschool Program

_____I would like my child to transition to the preschool program at 2 years. (As long as he/she is ready).

_____I would not like my child to transition to the preschool program. I want them to stay in the toddler program until 36 months then go to the preschool program.

_____ _____

Parent Signature Date

Parent Directory

_____ I would like my address, and phone number listed in Stepping Stones Parent Directory. If I choose Yes I understand that any parent can ask for my phone number or address and the school can give it to them.

Child's Name_____ Parents Name_____
Address _____ City _____
Phone _____

_____ I would not like my address, and phone number listed in Stepping Stones Parent Directory.

Child's Name _____

Parents Signature _____

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
( )	( )

Infant Needs and Services

0 – 18 months

Child's Name _____ Birth Date _____

Uses Pacifier? _____ When? _____

Needs Special Toy or Blanket? _____

Special Needs

_____

_____

_____

Diapering Instructions:

The parents will provide ointment or powder used on the child if you would like any used. Please indicate below when to use and what you would like to use:

Feeding Instructions:

Take A Bottle _____ Is the bottle warmed _____

Any food allergies? _____

Special instructions _____

_____

_____

_____ _____

Parent's Sign/Date-at enrollment Parent's Sign/Date—update 3 mon

_____ _____

Parent's Sign/Date—update 6 months Parent's Sign/Date-Update-9 months

Meal Benefit Form for Children
Program Year _____

Name of Child Care Center: Stepping Stones Learning center

Please read the instructions. If you need help completing this form, please call: 714-826-2311

Complete, sign, and return this form to: Charity Yarn

1. Child Information

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?

If all children listed are foster children, skip to Section 4.

2. Benefits

If you are receiving CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not complete Section 3**. Skip to Section 4.

CalFresh Case Number: _____

CalWORKs Case Number: _____

FDPIR Case Number: _____

3. All Other Households

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

☐ Check here if this household receives no income. Skip to Section 4.

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.

Names of all household members, including child(ren) listed above	**Earnings from work before deductions**	**Child support, alimony**	**Payments from pensions, retirement, Social Security**	**Earnings from any other income**
Example: Janet Smith	*$200/weekly*	*$150/twice a month*	*$100/monthly*	*$0*

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: _____ Check Here if No SSN: ☐

Signature of Parent or Guardian: _____ 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 an 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:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

If you choose to do so, please mark one of the following ethnic identities:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

For Agency Use Only

Categorical Eligibility:

CalFresh/CalWORKS/FDPIR household categorically eligible? ☐ Yes ☐ No

Foster child automatically eligible free? ☐ Yes ☐ No

Income Eligibility:

Annual Conversion (required if household reports various pay frequencies in Section 3):
Weekly times (x) 52, every 2 weeks x 26, twice a month x 24, monthly x 12

Total Household Income and Frequency: _____ per _____

Household Size: _____

Eligibility Classification:

Eligibility Classification: ☐ Free ☐ Reduced-price ☐ Base

Determining Official Name: _____

Determining Official Signature: _____ Date: _____