INFANT ENROLLMENT REGISTRATION APPLICATION

6601 Valley Circle Blvd. West Hills, CA 91307 | P. 818.884.8261 email: info@hillpointmontessori.com | www.hillpointmontessori.com

Date of Registration:		Date of Termination Status:	
CHILD INFORMATION			
Name of Child (Last, First, Middle Initial):			
Nickname:	Age:	Sex:	Date of Birth:
Child's Primary Language:	Parent/Guardian's Primary Language:		
Home Email Address:	Home Phone:		
Child's Home Address:			
PARENT/GUARDIAN			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Primary Residence: ☐ Mother ☐ Father ☐ Both ☐ Guardian		
List the family members your child lives with—include names and ages of siblings:			
Parent Updates (Initial)" (Date)			
Parent Updates (Initial)" (Date)			
Parent Updates (Initial)" (Date)			
Check the appropriate boxes for schedule, extra care hours if applicable, and how many days per week.			
□ Full Day Care Hours (7:00am - 6:00pm)	□ Regular Day Care Hours (8:30am - 3:00pm)		
□ Morning Care (7:00am - 8:30 am)	□ Afternoon Care (3:00pm - 6:00pm)		
PRIMARY CONTACT AND RELEASE PERSONS			
Parent/Guardian #1:		Relationship to Child:	
Home Phone:	Cell Phone:		
Home Address:			
Email Address:	Driver's License Number/State:		
Employer:	Employer's Address:		
Work Phone/Extension:	Work Hours:		
Parent/Guardian #2:		Relationship to Child:	
Home Phone:	Cell Phone:		
Home Address:			
Email Address:	Driver's License Number/State:		
Employer:	Employer's Address:		
Work Phone/Extension:	Work Hours:		
Parent/Guardian #3:		Relationship to Child:	
Home Phone:	Cell Phone:		
Home Address:			
Email Address:	Driver's License Number/State:		
Employer:	Employer's Address:		
Work Phone/Extension:	Work Hours:		
Parent/Guardian Signature:		Date	
Pages 1 and 2 must be updated every February and August			

ENROLLMENT REGISTRATION INFORMATION

EMERGENCY CONTACT AND RELEASE PERSONS

Please notify the school if an Emergency Release Person will pick up your child on a given day. For the safety of your child, we will request all authorized release persons to provide Government-issued photo identification at the time of pick-up. All persons below must be 18 or older, unless he/ she is the parent of the child.

Name #1:	Relationship to Child:
Home Phone:	Cell Phone:
Home Address:	Home Email Address:
Photo ID Type:	
Employer:	Employers Address:
Work Phone/Extension:	Work Hours:
Name #2:	Relationship to Child:
Home Phone:	Cell Phone:
Home Address:	Home Email Address:
Photo ID Type:	
Employer:	Employers Address:
Work Phone/Extension:	Work Hours:
Name #3:	Relationship to Child:
Home Phone:	Cell Phone:
Home Address:	Home Email Address:
Photo ID Type:	
Employer:	Employers Address:
Work Phone/Extension:	Work Hours:

The persons designated in this section will be contacted and are authorized to pick up my child if there is a medical or other emergency and I cannot be reached. Parent/Guardian must complete any state-specific emergency release form required by individual state child care licensing regulations. School staff will release your child only to you or to those persons you have listed above. Emergencies may prevent you from picking up your child; therefore, include those individuals whom you would authorize in such events. If you want a person who is not identified above to pick up your child, you must notify school staff in advance, in writing. Your child will not be released without prior authorization. In the event you call a pick-up authorization into the school because you are unable to submit your authorization in writing, we will use your personal information to verify your identity. For all children's safety, it is critical to use your secured access to enter the building and sign in your child in and out according to state child care licensing regulations. To ensure the safety of our schools staff and children, please do not share your secured access with anyone else. Please notify emergency contacts that they must bring government-issued identification when they pick up your child. If you must pick up your child after closing time, you will be charged a late fee per every 15 minute or portion of 15 minute period, per child, until the child is picked up. Per state licensing regulations, we may be required to contact local authorities after a certain amount of time. Please contact your Director for additional information.

Name of Child: Date:

Parent/Guardian Initial

ENROLLMENT REGISTRATION INFORMATION

ENROLLMENT AGREEMENT

Name of Child (Last, First, Middle Initial):_____Date of Birth:_____
Parent/Guardian Name:_____

Please initial each section listed below, then sign and date the last page.

_____REGISTRATION FEE: I understand that an annual, **non-refundable**, registration fee of $_____and material fee $_____shall be paid in advance to enroll my child. I understand that I may guarantee my child's enrollment for Fall by paying this fee no later than April each year. I also understand that the fees are subject to increase with advance notice.

_____FAMILY FEE: I understand a one-time fee of $_____ will be charged at the time of enrollment. Any siblings who may join in the future will not be charged this fee. There will be no refunds for any fees paid once the contracts are signed and my child's enrollment is guaranteed.

_____TUITION and MODIFICATIONS CONDITIONS: $_____per month is the current tuition rate for the program I have chosen. I understand that rates are subject to change with reasonable notice as conditions require. The school follows state specific required time frames on tuition and modifications notices.

_____ TUITION COMMITMENT: I understand that the tuition is paid annually for the [ ] 12 month or [ ] 10 month commitment. I understand that tuition can also be paid monthly and that if my child is withdrawn before the end of the school year I am liable to pay the tuition for the remaining months.

_____PAYMENT OF TUITION: I understand that tuition for the school year has to be paid at the time of enrollment. However, if I have chosen the monthly payment plan the payment is due by the first business day of each month. I understand that the tuition is based on a formula that spreads the school year tuition over the academic year calendar. I understand that there is no reduction in monthly tuition for months including holidays, sickness, vacations, and emergency closings.

_____LATE OR UNPAID TUITION: If payment in full is not received by the fifth of the month, I agree to pay a late payment fee of $30 per week that tuition is not received. All late fees are subject to change with reasonable notice. The school follows state specific required time frames on tuition and modifications notices. I understand that if my account is delinquent for more than one week, I may be asked to withdraw my child until my account is made current. The school cannot guarantee a child's spot will be held when a child is withdrawn due to non-payment of tuition.

_____CHARGES AND PROCEDURE FOR LATE PICK-UP: The school is open from _____am to _____pm, Monday through Friday all year, except for holidays. I understand that if I fail to pick up my child by the scheduled time I have chosen above, I will be charged a late fee of $15.00 per every 15 minutes or portion of fifteen minute period, per child, until the child is picked up.

_____ADDITIONAL FEES: I understand that children enrolled in summer programs, children attending during scheduled school breaks, and children attending after-school programs may pay a separate Activity Fee for attendance. All other age groups may be subject to Activity Fees as well. Please consult the Director for details.

_____RETURNED CHECKS: I understand that a processing fee will be charged to my account for all checks that are returned for any reason. An additional late tuition payment may be charged if the new payment is made after the fifth of the month. If more than two checks are returned, I will be required to pay by an alternate method of payment (cash, money order, or cashiers check).

_____DAILY PROCEDURE: I agree to sign my child in and out every day using the school's attendance procedure. I understand that my child is not permitted to sign him/herself out. If an authorized person will be dropping off or picking up my child from school, I will inform them that they need to sign my child in and out with the appropriate time.

_____ILLNESS: I understand that I will be notified should my child become ill during the day, and that I will pick up my child promptly, or make arrangements for an authorized emergency contact person to pick up upon such notification. If my child is exposed to or contracts a contagious disease, I agree to notify the school and I understand that my child will be re-admitted with a release note from the child's doctor.

_____MODEL RELEASE: The company, its agents, affiliates, and licensees, ❑ may ❑ may not use photographs, reproductions, images or sound recordings of my child for advertising, publicity or any other lawful purpose.

ENROLLMENT REGISTRATION INFORMATION

_____PHOTOGRAPHS, VIDEOS AND AUDIO TAPES: I understand and agree that, in consideration for being allowed to photograph, videotape or audio record my child on company property, I shall only use such recording for lawful and private home use, and will not publish, publicly display or

sell such recordings. I also understand that I must have written permission before capturing any image of the other children in the school or staff.

_____INTERVIEWING CHILDREN AND INSPECTING RECORDS: I understand that the state child care regulatory enforcement and administration agency and the local department of social services or child protective services has the authority to interview children or staff, to inspect and audit child or facility records, to interview children privately, to observe the physical condition of the children in the school, to make provisions for the independent medical examination by a licensed physician of any child, and to contact and instruct any other appropriate authority to do the same, without prior notice or consent by myself or by the school.

_____WITHDRAWAL: I understand my child's enrollment at Hill Point is for a full academic year. If I am withdrawing my child for reasons such as relocating or financial hardship, proof of such will be required as well as a 30 day notice to be submitted for early withdrawal.

_____HOLIDAYS: I understand that the school is closed on the following holidays: New Year's Day, Dr. Martin Luther King Jr.s Birthday, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day. School closings outside of this list may vary as posted on the school calendar. I agree that I will not receive a refund, credit or any other allowance for holidays. If a holiday falls on a weekend, it will be observed on either the preceding Friday or the following Monday.

_____ABSENCES/VACATIONS: I agree to inform the school immediately if my child will be absent on any day. I understand that no allowances, credits, refunds, or make up days shall be made for any absences (i.e. sickness).

_____INCLEMENT WEATHER OR OTHER DISASTERS: I understand that it is the company's intention to be open and provide child care service every weekday of the year, excluding holidays, but that inclement weather, natural/national disaster or major building issue may disrupt service from time to time. I will contact the school to ensure that it is open during inclement weather/natural disaster. I agree that in the event that the school is closed for an extended period of time, I will continue to be responsible for my tuition payments.

_____ALL POLICIES & STATE REGULATIONS: I understand that the above policies are not an all-inclusive list of policies, and that my child, my family members, authorized agents and I are bound by state child care regulations, the Family Handbook, and all other company policies, which may be modified at any time, without notice. I also understand that the child care regulations of the state in which my child attends may prevail over these policies when the state regulation is stricter. I further understand that my continued enrollment constitutes my acknowledgement of, and agreement to abide by, all policies and state regulations.

_____PARENT HANDBOOK: I have received a copy of the Parent Handbook. I have read and understand its contents and policies and agree to be bound by same.

_____NO MODIFICATIONS: No terms of this Agreement may be altered, revised, modified or deleted by any person except in cases of policy change or rate change to which both the Director and I must initial. Any alterations, revisions, modifications or deletions of any term of this Agreement are null and void.

_____ARBITRATION: Any disputes between Hill Point Montessori and its clients will be settled by arbitration.

We do not discriminate based on disability in the admission/enrollment or access to our programs or services. Information concerning the provisions of the Americans with Disabilities Act (ADA), including the rights provided there under, is available from the Director.

School management has reviewed these policies with me. I understand and will comply with the policies included in the Enrollment Agreement and Family Handbook. The policies in this contract will supersede all other previous documents.

Parent/Guardian Signature: Date:

Director Signature: Date:

Name of Child: Date:

Parent/Guardian Initial

ENROLLMENT REGISTRATION INFORMATION

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

In the event of an emergency requiring a physician's care, would you like us to call your family physician?
Yes ____" No____"

If yes, please provide the following information:
Physician's Name: _____Phone Number: _____

Address:_____City: _____

State:_____Zip: _____

I (we) _____and _____, do hereby state that I am (we are)

parent(s)/legal guardian(s) of _____, a minor child age _____, born

on _____, who resides with me (us) at _____

I (we), _____authorize, for emergency purposes only, a school- designated employee to transport the above minor by ambulance and consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the minor under the general supervision of any physician or surgeon licensed to practice medicine in the State of _____

Last Tetanus/Diphtheria Booster:_____

Allergies to drugs, foods or other:_____
Please list any special medications or pertinent
Information _____

Parent/Guardian signature:_____

Appeared before me and produced _____as identification.

Date: _____Director Signature:_____

Print name: _____

AUTHORIZATION FOR TRANSPORTATION, FIELD TRIP OR EMERGENCY

We may plan special field trips for the children away from the school. These trips are carefully arranged and shall be supervised by an adequate number of adults. You will always receive advanced notice of ALL field trips. We have your permission to take your child _____, on these field trips. For emergency purposes, we have permission to evacuate the premises. Our emergency evacuation site is posted in each school.
Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

PARENTS/GUARDIANS OF CHILDREN AGES 4 YEARS OLD AND OLDER ONLY:

We have permission to pick up your child, _____, on a daily basis from_____ school and take him/her on field trips.
Transportation off school grounds is only provided for children at least 4 years old and 40 pounds or more.
By signing this, you are certifying that your child is at least 4 years old and 40 pounds or more.

Parent/Guardian Signature:_____Date:_____

Witness: _____ Date:_____

ENROLLMENT REGISTRATION INFORMATION

ENROLLMENT CHECKLIST

Please review the entire Enrollment Registration Information packet and Parent Handbook with each family. Be sure that all forms are filled out completely with appropriate signatures. Review the child's health record and Immunizations for State compliance to ensure the physician has stamped/signed it and has filled in all the necessary dates.

OBTAIN SIGNED FORMS FROM FAMILY

- ❑ Standard Enrollment Packet
- ❑ Parent Handbook

REVIEW WITH FAMILY

- ❑ The child's first day
- ❑ Child guidance and classroom management (discipline policy)
- ❑ Tuition payment schedule, amounts and due dates
- ❑ Parent conferences and other communications, what to expect daily and/or weekly
- ❑ Process and Procedures of Security Access
- ❑ Authorized pickup, late pickup policy and emergency controls
- ❑ Child Custody Documents (if applicable)
- ❑ Clothing and other items to bring (labeled)
- ❑ Any pickup restrictions
- ❑ Any field trip restrictions
- ❑ Any photo restrictions
- ❑ Immunization/Health information
- ❑ Annual registration and supply fee and one time family fee
- ❑ Late fees
- ❑ Vacation policy
- ❑ Special needs
- ❑ Absenteeism policy
- ❑ Sick policy
- ❑ Meals
- ❑ Allergies
- ❑ Security deposit (if applicable)
- ❑ Medication policy
- ❑ Relevant curriculum features for child's age group
- ❑ Infant/Toddler Needs Services Plan (if applicable)

The information above was reviewed with me and all of my questions have been answered to my satisfaction. I have a clear understanding of all the policies of Hill Point Montessori.

Name of Parent/Guardian:_____ Signature: _____

Relationship: _____ Date: _____

Name of Director:_____ Signature:_____ Date: _____

Name of Child: _____ Date: _____

Parent/Guardian Initial _____

HILL POINT MONTESSORI

Infant Needs and Service Plan

*This needs and service plan will be updated every 3 months

Date: _____

Child's Name_____ Date of Birth: _____

Mother's Name:_____ Daytime Phone: _____

Father's Name _____ Daytime Phone: _____

Feeding

____ Bottle; Formula (What Brand) _____ ____Breast Milk Uses a Sippy cup: Yes No

What is your child's feeding schedule? _____

_____

_____

What is the longest period of time you allow your child to go between feedings? _____.

What needs does your child have during their feeding: (ex. Needs to always be burped, sit up after feeding, etc.)_____

_____

_____

Foods

Does your child eat: Baby Foods____ Table Food____ (menu will be provided)

List all food allergies, food sensitivities, or feeding issues: _____

_____

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

_____

Sleeping

Does your child use a pacifier? ___Yes ____No

What is your child's current sleeping schedule _____.

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

_____

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

****If a blanket is used, the infant is placed at the foot of the crib with a thin blanket tucked around the crib mattress, reaching only as far as the infants' chest.**

Diapering

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

_____

Please note you will need to complete a topical ointment form and update this every 90 days. We cannot put on any cream without a prescription or signed physician's authorization if it is a prescribed ointment.

General Information

Does your child have any special needs: _____

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

_____

_____

_____

Parent Signature_____ Date: _____

Updated Parent Signature_____ Date: _____

Updated Parent Signature_____ Date: _____

Teacher Signature_____ Date: _____

Teacher Signature_____ Date: _____

Teacher Signature_____ Date: _____

Infant Daily Schedule

Time	Feeding	Napping
6:30 am		
7:00 am		
7:30 am		
8:00 am		
8:30 am		
9:00 am		
9:30 am		
10:00 am		
10:30 am		
11:00 am		
11:30 am		
12:00 pm		
12:30 pm		
1:00 pm		
1:30 pm		
2:00 pm		
2:30 pm		
3:00 pm		
3:30 pm		
4:00 pm		
4:30 pm		
5:00 pm		
5:30 pm		

Additional comments:

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

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 Division

ADDRESS

300 Continental Boulevard

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
El Segundo	90245	(424) 301-3077

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)
Hill Point Montessori Preparatory School	6601 Valley Circle Blvd,West Hills, CA 91307

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.

5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***

6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.

7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing Division

   Licensing Office Address: 300 Continental Blvd #290 A, El Segundo, CA 9024

   Licensing Office Telephone #: (424) 301-3077

8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.

9. Receive, from the licensee, the Caregiver Background Check Process form.

10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (8/08) (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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee._____
Name of Family Child Care Home

Signature (Parent/Authorized Representative) _____Date_____

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

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

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

Hill Point Montessori
FACILITY NAME TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

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

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.