

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

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME _____

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME _____

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME _____

IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? _____

SEX _____ BIRTH DATE _____

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

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

DATE OF LAST PHYSICAL/MEDICAL EXAMINATION _____

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

WALKED AT* _____

MONTHS

BEGAN TALKING AT* _____

MONTHS

TOILET TRAINING STARTED AT* _____

MONTHS

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

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 GET UP?*

WHAT TIME DOES CHILD GO TO BED?*

DOES CHILD SLEEP DURING THE DAY?*

WHEN?*

DOES CHILD SLEEP WELL?*

HOW LONG?*

WHAT ARE USUAL EATING HOURS?

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

BREAKFAST _____

LUNCH _____

DINNER _____

BREAKFAST _____

LUNCH _____

DINNER _____

ANY FOOD DISLIKES? _____

ANY EATING PROBLEMS? _____

IS CHILD TOILET TRAINED?*

IF YES, AT WHAT STAGE?*

YES NO

ARE BOWEL MOVEMENTS REGULAR?*

WHAT IS USUAL TIME?*

YES NO

WORD USED FOR "BOWEL MOVEMENT"*

WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH _____

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? IF YES, NAME OF DOCTOR _____

YES NO

DOES CHILD USE ANY SPECIAL DEVICE(S) IF YES, WHAT KIND _____

YES NO

PARENT'S EVALUATION OF CHILD'S PERSONALITY _____

DOES CHILD TAKE PRESCRIBED MEDICATION(S)? IF YES, WHAT KIND AND ANY SIDE EFFECTS _____

YES NO

DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? IF YES, WHAT KIND _____

YES NO

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

HAS THE CHILD HAD GROUP PLAY EXPERIENCES? _____

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

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

REASON FOR REQUESTING DAY CARE PLACEMENT _____

PARENT'S SIGNATURE _____

DATE _____

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

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

KINNEY, LINDA & JAN FAMILY CHILD CARE 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

()

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:

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NAME

COMMUNITY CARE LICENSING DIVISION

ADDRESS

7575 METROPOLITAN DR., STE 110

CITY

SAN DIEGO

ZIP CODE

92108

AREA CODE/TELEPHONE NUMBER

(619) 767-2200

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)

KINNEY, LINDA & JAN FAMILY CHILD CARE

(PRINT THE ADDRESS OF THE FACILITY)

2104 PENTUCKETT AVE. SAN DIEGO CA 92104

(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 REGIONAL OFFICE
Licensing Office Address:	7575 METROPOLITAN DR., STE 110 SAN DIEGO CA 92108
Licensing Office Telephone #:	(619) 767-2200
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 (8/09)

(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. KINNEY, LINDA & JAN FAMILY CHILD CARE
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

LIC 995A (8/08)



Travel and Activity Authorization



_____ I give permission for my/our child, _____, age _____, to leave the family child care home for travel in a car or on public transportation for any reason. Conditions under which children are transported are described under the Provider Policies.

_____ I give permission for my/our child, _____, to walk to and/or participate in activities geared for my child but away from the child care home under supervision of a provider or adult helper. My provider will inform me in advance of field trips beyond the immediate neighborhood.

_____ I give permission for my school-aged child, _____, to participate in _____ (name of activity), outside of the residence. I understand my child will not be under the supervision of the child care provider, substitute, or helper.

Date _____ Signed _____
(Name of parent or guardian of child)

ENROLLMENT WORKSHEET

Child Nutrition Program of Southern California

7777 Alvarado Road, Suite 700

La Mesa

CA 919420000

CHILD INFO:

First Name _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: ____/____/____ Enrollment Date: ____/____/____ Sex: ____ Male ____ Female

PARENT INFO:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ____ Male ____ Female Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Email: _____

FORMULA OPTION:

FOOD OPTION:

PAYMENT SOURCE:

____ Parent Supplies Breast Milk or Formula
____ Parent Accepts Provider-Supplied Formula

____ Parent Supplies Additional Food and Refuses Provider's Foods
____ Provider Supplies Additional Foods When Developmentally Appropriate

____ Private/No Pay
____ DHS/County

Name of Parent Formula: _____

SCHOOL INFO:

ETHNICITY:

RACE:

____ School Age ____ AM Kindergarten ____ AM Headstart ____ Hispanic/Latino ____ American Indian / Alaska Native
____ Home School ____ PM Kindergarten ____ PM Headstart ____ Not Hispanic or Latino ____ Asian
____ All Year School ____ All Day Kindergarten ____ All Day Headstart ____ Native Hawaiian / Pacific Islander
____ White

School Name: _____

School Number: _____ School District: _____

School Depart Time: _____ AM / PM Return Time: _____ AM / PM

Days Attending School: ____ MON ____ TUE ____ WED ____ THU ____ FRI

CHILD ATTENDANCE:

I anticipate the Days my child will participate will be: ____ MON ____ TUE ____ WED ____ THU ____ FRI ____ SAT ____ SUN ____ Days will vary
Drop Off Time _____ AM / PM Pick Up Time _____ AM / PM ____ Times will vary

I anticipate the Meals my child will participate will be: ____ Breakfast ____ AM Snack ____ Lunch ____ PM Snack ____ Dinner ____ Evening Snack

Parent/Guardian Signature: _____ Date: _____

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