www.childrenschoicepreschool.com

Executive Director: Jennifer House

☐ 1465 E. Madison Ave El Cajon, CA 92019 (619) 442-4014	☐ 1268 N. Second St. El Cajon, CA 92021 (619) 442-1685	☐ 9748 Los Coches Rd Ste #9 Lakeside, CA 92040 (619) 561-1178

CHILD REGISTRATION PACKET

Child's Name: _____ Date of Birth: _____

Date Registered: _____ Start Date: _____

Group/Room: _____ Account Key: _____

Days Attending:	M	T	W	TH	F	Full	Half
Hours:							

Tuition per week:		Registration fee paid:		Summer Activity Fee:	$145-School Age $55-Preschool

Alternative Payment Provider: _____

Required Forms:

- ☐ Emergency Information
- ☐ Consent for Medical Treatment
- ☐ Parent/Center Contract
- ☐ Enrollment Questionnaire
- ☐ Physician's Report
- ☐ Immunization Record
- ☐ Parent Handbook
- ☐ Sick Policy
- ☐ Parent's Rights Form
- ☐ Child's Rights Form
- ☐ Assessment Form
- ☐ Blue Immunization Card
- ☐ Photo Release

Allergies to food or milk? Yes or No

(circle one)

Please Bring In:

- Immunization Record
- Fitted Crib Sheet and Blanket
- Extra change of clothes
- Diapers and Wipes (if applicable)
- Baby Formula (if applicable)

Parent/Center Contract

I, _____, agree to enroll my child, _____in Children's Choice Learning Connection beginning on _____.

_____1. Tuition will be $_____ per week.

_____2. Overtime charges are $1.00 per minute, per child, if child is left at the center past 6 pm.

_____3. Charges for returned checks are $30.00 per check. Once there are two returned checks, it will result in CASH ONLY payment basis.

_____4. Tuition is due every Monday by 6 pm. If payment is not received by 6 pm, a late fee of $25.00 will be assessed to my account.

_____5. I am responsible for the FULL tuition amount regardless of missed day due to illnesses or holidays.

_____6. Children may be taken from the facility only by the persons that are specified on the "Identification and Emergency Information" form.

_____7. A paid two weeks' notice is required before dropping my child(ren) from the program.

_____8. In addition to the weekly tuition, a Summer Activity Fee will be **due June 1st** every summer. The fee is $145 for school age or $55 for pre-school age.

_____9. I have received a CCLC Parent Handbook. I also understand that I am responsible for reading and asking any additional questions in reference to Children's Choice's policies and procedures.

_____ _____

Parent's Signature Date Signed

_____ _____

Director's Signature Date Signed

Sick Policies

Dear Parents,

It is our goal to provide your child with the safest and healthiest environment. Children's Choice has taken positive steps towards this goal. We have enhanced our health policies to include comprehensive hygiene and universal precaution practices which will help to reduce the spread of illnesses.

We believe that Children's Choice hygiene and universal precaution practices can make a difference in creating a healthier environment. We will be monitoring our progress toward the reduction of illness among children and staff. In order to obtain this goal, we will need your help as follows:

- If your child does not feel well enough to attend the center, please call the center on your child's first day of absence.
- If your child is not feeling well, but is not ill enough to see a doctor, give us a description of your child's symptoms (stomach ache, vomiting, fever, runny nose, diarrhea, etc.) when you call.
- If you have seen a doctor, please tell the director the physician's diagnosis when you call.
- When your child returns to the center, please update us on his or her condition.

Children will be excluded from the center, or you will be called to come pick them up for the following reasons:

- FEVER: the child may not return until the fever is gone for 24 hours without medicine
- DIARRHEA: more than one loose, watery stool
- VOMITING: may not return until vomiting has stopped for 24 hours
- PINK EYE/EYE INFECTION: may return after using the drops for 24 hours
- RASHES: especially with a fever or itching
- SORE THROAT: especially with a fever or swollen glands
- CHICKEN POX: may return after all sores have scabs (usually 5-7 days)
- Too sick to participate: unusually tired, pale, lack of appetite, confused or cranky

Sick children will not be accepted at school, and we will strictly enforce these policies. Children's Choice policies for health and hygiene are the most comprehensive and progressive in the field of childcare, and we sincerely believe that, as a result, our children and staff members will experience fewer absence days due to illness.

We appreciate your cooperation and understanding.

_____ _____

Parent Signature Date

EMERGENCY INFORMATION

Child's Name:	**Child's Birth Date:**
Address:	**Child's Age:** **Sex:**
City: **St:** **ZIP:**	**Home # ( )**
Mother/Guardian's Name:	**Cell # ( )** Provider (e.g. Verizon/AT&T etc,)
Mother/Guardian's Employer:	**Work # ( )**
Father/Guardian's Name:	**Cell # ( )** Provider (e.g. Verizon/AT&T etc,)
Address:	
City: **St:** **ZIP:**	**Home # ( )**
Father/Guardian's Employer:	**Work # ( )**
Mother/Guardian's primary email:	
Father/Guardian's primary email:	

Persons Authorized to Pick up Child

1) Name:	**Relationship:**
Address:	**Phone #**
2) Name:	**Relationship:**
Address:	**Phone #**
3) Name:	**Relationship:**
Address:	**Phone #**
4) Name:	**Relationship:**
Address:	**Phone #**

***PLEASE REMEMBER:** All persons authorized to pick up your child **MUST** have a valid identification card with them in order for the child to be released.

PHOTO RELEASE

_____**Yes**, I hereby give Children's Choice Learning Connection permission to use my child's photograph and likeness in all forms of media for advertising, trade, and any other lawful purposes.

I attest that I am the parent/guardian of the child(ren) stated below.

I have read this release form and approve of its terms.

Child(ren) Name(s):_____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

_____**No,** I, _____, do not give my permission for my child's photo to be used for any purposes.

Parent/Guardian Signature: _____

Date: _____

Permission to apply Sunscreen

I give permission for the staff at Children's Choice Learning Connection to apply sunscreen / sun block to my child. I understand that Sunscreen / Sunblock cannot be shared with other kids/staff.

PARENTS MUST PROVIDE SUNSCREEN / SUN BLOCK

Child's Name:_____

Parent's Signature: _____

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–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, I HEREBY GIVE CONSENT TO

_____ TO PROVIDE 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 WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE	CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE (CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

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

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)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
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)

_____ . 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:

other:

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 Practioner

LIC 701 (8/01) (Confidential)