Executive Director: Jennifer House – Tax ID: 33-0627685

1465 Madison Ave.	350 Prescott Ave	1268 N. Second St. and	9748 Los Coches Rd. #12	8824 Cottonwood Ave.
El Cajon, CA 92019	El Cajon, CA 92020	1164 N. Second St.	Lakeside, CA 92040	Santee, CA 92071
(619) 442-4014	(619) 499-7524	El Cajon, CA 92021	(619) 561-1178	(619) 457-0381
Licenses:	Licenses:	(619) 442-1685	Licenses:	Licenses:
3766006610/376600030/	376701437/376701438/	Licenses:	376700666/376700667/	376701224/376701225
376600594	376701439	376700510/376701239	376700668	

CHILD REGISTRATION PACKET (Preschool 2-5 years)

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 on _____ $150 Summer Activity Fee: $65.00

Alternative Payment Provider: _____

Required Forms:

- □ Identification 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
- □ Photo Release
- □ Automated Payment Form
- □ Permission to apply Sunscreen Form
- □ Rights of the Licensing Agency
- □ Meal Plan Application/Meal Benefit Form
- □ Emergency Card
- □ Blue Immunization Card

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)

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 payments are $30.00 per transaction. Once there are two returned items, 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. If tuition is not current by the end of the second week, child may not return until tuition is paid in full, including all incurred late fees. Many classrooms have waiting lists and your child's spot might be filled if tuition is past due.

__ 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 $155 for school age or $65 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 Signature Date Director Signature Date

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: _____

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) ___Children's Choice Learning Connection_____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____ CVV (3 digit code) _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

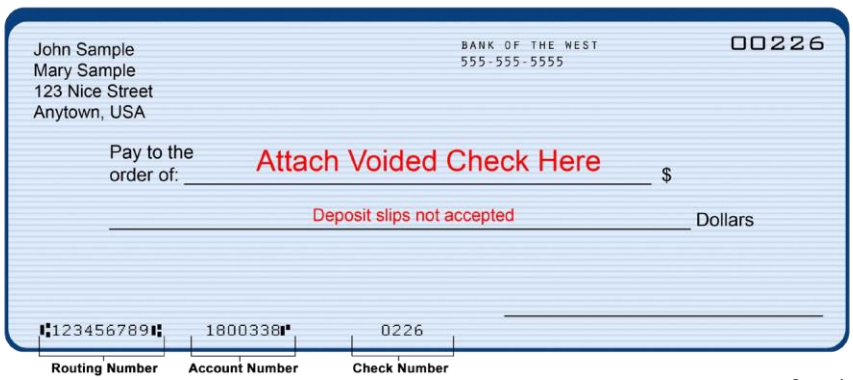
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
_____
Employee Signature
_____



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Rights of the Licensing Agency: Section 101200 (b) & (c)

The Department or Licensing Agency shall have the authority to interview children, or staff, and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any children or staff members. The Department has the authority to inspect, audit, and copy child or child care center records upon demand during normal business hours. Records may be removed for copying if necessary.

_____

Child's Name

_____ _____

Parent/Guardian Signature Date

_____ _____

Center Director Signature Date

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	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER 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?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST _____
	LUNCH	LUNCH _____
	DINNER	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.

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