

Marina Montessori School
2301 Ximeno Ave. Long Beach, CA • 562-494-4641

Student Application Packet

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/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 |
|--|-------|---|-------|--|-------|
| <input type="checkbox"/> Chicken Pox | | <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Poliomyelitis | |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Ten-Day Measles (Rubeola) | |
| <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Whooping cough | | <input type="checkbox"/> Three-Day Measles (Rubella) | |
| <input type="checkbox"/> Hay Fever | | <input type="checkbox"/> Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| | | |
|--|------------------------|---|
| DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?* | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* | WHAT IS USUAL TIME?* |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> 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: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

| | | | |
|--|--------------------|--|--------------------|
| DOES CHILD USE ANY SPECIAL DEVICE(S): | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? | IF YES, WHAT KIND: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

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- 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
()

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)

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/DaP/ 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: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

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.