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

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
( )	( )

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

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?)		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

EMERGENCY / DISATER INFORMATION

Child's Name _____ Birthdate _____
Home Addres _____
Parents' Names _____
Parents' Address (if different) _____
Business Address _____ Phone _____

Persons Authorized to take child from center

_____
_____
_____
_____

Necessary Medical Information
Allergies _____ Ongoing Medication _____
Insurance Carrier _____ Policy # _____

I hereby give permission to Blessed Sacrament to consent to any emergency medical treatment for my child in the event that parents cannot be reached.

Signature _____
Relationship _____ Date _____

EMERGENCY / DISATER INFORMATION

Child's Name _____ Birthdate _____
Home Addres _____
Parents' Names _____
Parents' Address (if different) _____
Business Address _____ Phone _____

Persons Authorized to take child from center

_____
_____
_____
_____

Necessary Medical Information
Allergies _____ Ongoing Medication _____
Insurance Carrier _____ Policy # _____

I hereby give permission to Blessed Sacrament to consent to any emergency medical treatment for my child in the event that parents cannot be reached.

Signature _____
Relationship _____ Date _____

GET ACQUAINTED FORM

You can help us get acquainted with your child must faster by filling in the information below:

Child's name: _____ Age: _____ Birthday: _____

Child's nickname: _____

Names and Ages of Brothers: _____

Names and Ages of Sisters: _____

Religious Affiliation: _____

Pets at Home and Names: _____

Hour of Bedtime: _____ Take a nap? _____

Favorite Pastime: _____

High or Low Energy Level: _____

Prefer Quiet or Active Play: _____ Talkative or Quiet: _____

Favorite Toy: _____

Hours of TV Daily: _____ Favorite Programs: _____

Does He/She color at home? _____ Paint? _____ Use scissors? _____ Glue? _____

Favorite Activity with Father: _____

Favorite Activity with Mother: _____

What method of discipline do you use? _____

Any fears? _____ Allergies? _____

Right or Left handed: _____ Noticable speech problems? _____

Word used for urinating: _____ Bowel movements: _____

Father's profession: _____ Mother's Profession: _____

One or Two Parents family: _____ Mom or Dad: _____

Any other adult family members part of the household? _____

Any other comments of interest: _____

ADMISSION AGREEMENT

I have received a copy of the parent handbook and agree to comply with the policies set forth by Blessed Sacrament Childern's Learning Center.

My child _____ will attend ____ days per week, from _____ a.m. to _____ p.m. Extra hours and days may be arranged with the director's consent and will be charged at $3.50 and hour or $30 for a ½ day, $35 for a ¾ day, and $40 for a full day.

Tuition will be due in full on the 1st of every month, unless otherwise arranged with the director. I will be paying tuition on the _____ in the amount of _____. Tuition payments will be made payable to Blessed Sacrament Children's Learning Center. Payments may be made by credit card, check or cash. Automatic credit card payments can be set up. There will be a $15 fee for any returned check. Tuition payments may be requested to be in form of a cashier's check if there are more than two incidents of returned checks.

Tuition that is delinquent more than two months, will result in the possible termination of services. After two months of non-payment, a notice will be sent requesting payment within 3 weeks. If payment is still not made, a final notice will be sent by certified mail. If within 10 days of receipt of letter, payment is still not made, a third party will be called to rectify the situation and collect any unpaid fees.

There are no discounts for student absences. However, each family will be entitled to 1-week vaction during the course of the year. The week must be taken in 1 increment. Tuition payments are based on a yearly amount divided into even monthly payments. Therefore, in months that have holidays or other days when the school will be closed., tutuion will remain the same. Look at the handbook and at the school calendar for specific dates.

I have read the above information and agree to abide by the policies of Blessed Sacrament Children's Learning Center.

Parent Signature: _____ Date: _____

Family Representative: _____ Date: _____

THIS IS THE WAY I CHOOSE TO HELP MY CHILD'S SCHOOL

- ☐ I CAN HELP SUPPLY THE SCHOOL WITH PLASTIC FORKS & SPOONS (BI-MONTHLY)
- ☐ I CAN HELP SORT THE SEES CANDY FUNDRAISER (LATE NOV. EARLY DEC.)
- ☐ I CAN HELP ON SCHOOL PICTURE DAYS (IN SEPT. & SUMMER)
- ☐ I CAN HELP WITH GETTING DONATIONS FOR THE SILENT AUCTION
- ☐ I CAN HELP WITH SUPPLYING DINNER SIZE PAPER PLATES (BI-MONTHLY)
- ☐ I CAN HELP WITH THE TEACHER APPRECIATION EVENT, WITH SET UP OR PREPARING FOOD, OR WATCHING CHILDREN (IN MAY)
- ☐ I CAN HELP WITH PREPARING HOT LUNCHES AND/OR SNACKS
- ☐ I CAN HELP SUPPLY BOXED TISSUES AND BABY WIPES
- ☐ I CAN SEW, OR I HAVE A FRIEND OR RELATIVE THAT CAN HELP MAKE A QUILT FOR YOUR AUCTION IN THE SPRING
- ☐ I CAN HELP SUPPLY PAPER NAPKINS & SMALL PAPER CUPS (MONTHLY)
- ☐ I CAN BE ON THE AUCTION COMMITTEE AND HELP WITH DONATIONS BASKETS, DECORATIONS, DESSERTS OR WHERE EVER NEEDED

MY CHILD'S NAME IS: _____

MY NAME IS: _____

MY PHONE NUMBER IS: _____

FUNDRAISING RESPONSIBILITIES

I understand that my child's school is funded entirely by the tuition fees collected each month and from the fundraising events that happen during the year.

I understand that in order to keep the tuition fees as reasonable as possible, while at the same time, maintain the high quality of the school program, it takes every family's participation in the fundraisers.

I understand that I may choose how I will participate in the various fundraisers, but at the monetary responsibility for each family is $300 earned for the entire school year.

I understand that if I do not wish to participate in any or all the fundraisers, then I will donate $300, spread out evenly over 10 months and added to my tuition amount, or paid in total.

I understand that if I choose to pay the entire amount, then my participation in the fundraising activities will not be required or expected, but only at my choosing.

I understand that if I choose to participate in the fundraisers in order to meet my family's responsibility then I will have to have earned $300 profit at the end of the school year.

I understand that if I do not meet the monetary amount required, that I will be responsible for making up the difference by the end of the current school year.

This is how my family chooses to participate in the fundraising responsibilities.

We will participate in

- ☐ Selling See's Candy (FALL)
- ☐ Participating in the Silent Auction (SPRING)
- ☐ Participating in the Wheel-a-Thon

We will donate the $300 requested

- ☐ In one payment
- ☐ In _____ payments (choose how you want to split it up)
- ☐ Spread out evenly over 10 months and added to my tuition payment

Child's name _____

Parent's signature _____ Date: _____

LOTION AND CHAPSTICK UTILIZATION PERMISSION FORM
ALL CHAPSTICKS AND LOTION MUST HAVE NAME ON THEM

Date: _____

Name of Child: _____

As the parent or the guardian of the above child, I give my permission for staff at:

Blessed Sacrament Children's Learning Center

To apply lotion and chap stick that I provide to my child, as specified below, when needed. I understand that lotion may be applied to exposed skin, including but not limited to the face, tops of ears, nose, and bare shoulders, arms, and legs.

Additionally, I have checked and/or indicated below my directives regarding the type and application of lotion.

The staff of **Blessed Sacrament Children's Learning Center** may also uses the lotion of their choice, in keeping with applicable federal and state standards, except for the following (if specified):

_____

Only use the following type(s)/SPF lotion

_____

For medical or other reasons, please don't apply sunscreen to the following areas of my child's body:

_____

Parent's Full Name (print): _____

Parent's Signature: _____ Date: _____