Los Altos Grace Preschool * 6565 Stearns Street * Long Beach, CA 90815 * (562) 430-6813

ENROLLMENT & EMERGENCY CONTACT INFORMATION

STUDENT'S LAST NAME _____ FIRST _____ MIDDLE _____ Date of Birth _____

Address (Street) _____ Apt. # _____ City _____ Zip _____ ( ) Home Telephone Number _____

☐ Father
☐ Stepfather
☐ Guardian
☐ Not in Home

Name _____ Occupation _____

Cell Phone: ( ) _____

Name of Employer _____ Work Telephone (w/extension) _____

☐ Mother
☐ Stepmother
☐ Guardian
☐ Not in Home

Name _____ Occupation _____

Cell Phone: ( ) _____

Name of Employer _____ Work Telephone (w/extension) _____

Out of State Disaster Contact:
Name _____ ( ) Phone # _____

EMERGENCY CONTACT INFORMATION
EMERGENCY NUMBERS – MUST BE COMPLETED and only the people listed on this form will be permitted to pick up your child in the event of an emergency (earthquake, natural disaster, etc.), illness or injury. Any other persons must have written authorization from parent or guardian.

PERSON RESPONSIBLE FOR CHILD: _____

Please list EMERGENCY contacts name, telephone number, and relationship in the order you wish them to be called.

NAME	ADDRESS	TELEPHONE (with area code)	RELATIONSHIP

ADDITIONAL CONTACT INFORMATION

Names of additional persons authorized to take my child from the facility on a regular basis (i.e. carpools):

NAME	TELEPHONE (with area code)	RELATIONSHIP

Please name specific person(s) who may NOT take child away from school. If this person is the child's parent, a restraining order must be on file in the school office. _____

For Office Use Only: _____ Date enrolled: _____ Date left: _____

Los Altos Grace Preschool * 6565 Stearns Street * Long Beach, CA 90815 * (562) 430-6813

AUTHORIZATION FOR EMERGENCY CARE

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Initial

[ ] I hereby authorize Los Altos Grace Schools to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified physician called by Los Altos Grace Schools may treat and do whatever is necessary for the health and well-being of my child. It is understood that a conscientious effort must be made to notify us (parents) before such action will be taken. I also agree to accept responsibility for the cost of above medical services not covered by school insurance.

Doctors Name: _____ Address _____ Phone # (___) _____

Name of Medical Insurance _____ ID Number _____

Dentist Name: _____ Address _____ Phone # (___) _____

Dental Insurance _____ ID Number _____

Does your child have any special/serious health problems? Yes ☐ No ☐ If yes, please explain:

_____

Allergies to food: Yes ☐ No ☐ If yes, please list: _____

Allergies to environment: Yes ☐ No ☐ If yes, please list: _____

Allergies to medication: Yes ☐ No ☐ If yes, please list: _____

Name of Current Medications _____

Will your child be taking medication(s) at school? Yes ☐ No ☐ If yes, please list _____

_____

A "Parent Consent for Administration of Medications" form must be on file in order for a medication to be administered at school.

Signatures: This form must have two signatures.

MOTHER/LEGAL GUARDIAN _____ Date _____

FATHER/LEGAL GUARDIAN _____ Date _____

It is our usual practice to release children to either parent. If, through custody, guardianship, or some other arrangement that places a restriction on one or both parent's ability to pick up their child from school, please provide the office with appropriate documentation of such arrangement.

LOS ALTOS GRACE PRESCHOOL
6565 Stearns Street
Long Beach, CA 90815
(562) 430-6813

COVID-19 Illness Policy Update - 2021

Los Altos Grace Preschool has updated our Illness Policy as a result of Public Health Guidelines related to COVID-19 as follows:

Each morning, please check your child for signs of illness including, but not limited to:

- Respiratory symptoms
  - Nasal discharge and/or congestion
  - Shortness of breath
  - Sneezing, coughing
- Other symptoms of illness such as
  - Conjunctivitis
  - Diarrhea, nausea, vomiting
  - Skin rash
- Temperature of or above 100.4

If a child displays any of the above symptoms, they must stay home. If symptoms are displayed during the school day, the child will be isolated and must be picked up promptly.

During the check in process, parents will confirm that during the last 24 hours, their child:

- Has not been ill with fever, chills, cough, shortness of breath, no loss of taste or smell
- Has not had contact with COVID-19 in the past 10 days
- Has not received any fever reducing medicine

If a child is home with any of the above symptoms of illness, they must be fever/symptom free for 24 hours before returning to school.

Additionally, if the symptoms are consistent with COVID-19 (fever and/or cough, diarrhea or vomiting, loss of taste or smell) a medical provider should be consulted, and if recommended, the child should be tested for COVID-19. If negative, the child must stay home until fever/symptom free for 24 hours. If positive, the child must stay home for 10 days from symptom onset and until fever/symptom free for 24 hours.

Please notify the school if or someone in your household has tested positive for COVID-19. In this case, your child must remain home for 10 days from last exposure to infected person, or 10 days from test date if no symptoms.

If a child or staff member tests positive for COVID-19, we will immediately contact the Department of Public Health and follow their recommendations. All staff and families will be notified of a confirmed case of COVID-19 in someone connected to our facility.

I have read and agree to this Illness Policy Update.

_____
Child's Name

_____ _____
Parent Signature Date

LOS ALTOS GRACE PRESCHOOL
Admission Agreement

Please initial on each line below to acknowledge that you have read each point.

_____ I realize my responsibility to keep my child's tuition up to date. I understand that all tuition payments are due on the first of each month and delinquent after the tenth. I agree to pay a $20.00 late fee for any tuition payment not received by the 10th of the month.

_____ I agree to pay a $25.00 service charge in the event that my check is returned to the school by the bank because of insufficient funds.

_____ I have read the "Mark Your Calendar – Preschool Schedule" form and am aware of which days the school will be closed during the school year.

Child's Name _____

Parent Signature _____

Date _____

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
Department of Social Services - L.A. Child Care East

ADDRESS
1000 Corporate Center Drive Suite 200 B

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterey Park	91754	(323) 981-3374

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)

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
( )	( )

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:

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.

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

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: Department of Scoial Services - L.A. Child care East

   Licensing Office Address: 1000 Corporate Center Drive, Suite 200B

   Licensing Office Telephone #: (323) 981-3374

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.

Los Altos Brethern Church Preschool
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

LOS ALTOS GRACE SCHOOLS

PARENT PHOTO POLICY

As your child participates in special events, lessons, or is just having fun on the playground, teachers and parents often have great photo and video opportunities. Our policy regarding photographing and videoing children while at school is as follows:

- Photos/Videos by parents are permitted at special events (special days, chapels, Jog-a-thon, field trips, etc.) without permission from administrators/teachers.
- Parents **should** ask permission from the teacher or administrator before taking photos/videos on the playground or in the classroom on a "regular" school day.
- Parents should exercise caution when posting photos/videos of their children (or children other than your own) on any social media outlets (Facebook, Instagram, Twitter, etc.)
- Photos/Videos taken by the teachers may be used for school purposes such as yearbook, class displays, slideshows, videos, website and school social media accounts such as Instagram or Facebook.

The safety of our students is a top priority. Our purpose in establishing and enforcing this policy is to protect your children, while still allowing you to record and preserve the sweet memories of your child's school year.

NOTE: If you do not want photos/videos of your child taken for school purposes, please indicate that in the appropriate place.

Please check the box of choice and return this letter to the school office.

_____ I give Los Altos Grace Schools permission to take photos/videos of my child for school purposes.

_____ I do not want photos/videos of my child taken for school purposes.

Child's Name _____ Grade _____

Parent Signature _____ Date _____

Sincerely,

Mrs. Debra Martin
Elementary Principal

Mrs. Andrea Witbeck
Preschool Director

6565 Stearns Street Long Beach CA 90815