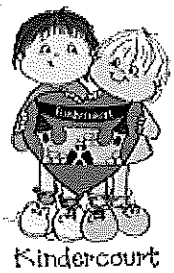


Kindercourt Schools

Records for New Children

( ) POLICIES AND PROCEDURES SIGNATURE PAGE

( ) ATTENDANCE AGREEMENT

( ) EMERGENCY CONTACT NUMBERS

( ) IDENTIFICATION AND EMERGENCY INFORMATION

( ) PARENT'S REPORT

( ) MEDICAL CONSENT FORM

( ) PARENT'S RIGHTS

( ) PERSONAL RIGHTS

( ) FOOD ALLERGY ACTION PLAN

( ) PHYSICIAN'S REPORT

( ) IMMUNIZATION RECORD

CHILD'S NAME _____

DIRECTOR'S SIGNATURE _____

DATE ENROLLED _____ DATE COMPLETED _____

LAST DAY AT KINDERCOURT _____

Kindercourt Academy 1225 Greenwood Ave San Carlos Ca 94070 591-4882
Kindercourt Laurel 1601 Laurel Street San Carlos Ca 94070 592-7980
Kindercourt San Mateo 211 So Delaware San Mateo Ca 94402 344-6612

Kindercourt Schools

Established 1979

I have read and received a copy of the Kindercourt Policies and Procedures.

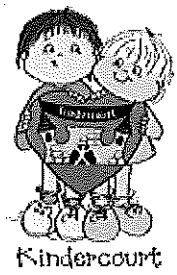
I understand the school administration may amend the Policies and Procedures of Kindercourt at any time. Parents will be notified if changes are made. Additional copies of these policies are available upon request

Child's Name _____

Parent Signature _____

Date _____

Kindercourt Academy 1225 Greenwood Ave San Carlos Ca 94070 650-591-4882
Kindercourt Laurel 1601 Laurel Street San Carlos Ca 94070 650-592-7980
Kindercourt San Mateo 211 So Delaware San Mateo Ca 94402 650-344-6612



Kindercourt Schools

Tuition/Attendance Agreement

I, _____, agree to pay the monthly tuition for my child,

_____. My child will be attending Kindercourt

as follows: _____ half days/full days.

I have circled the tuition option I wish to use:

( ) Tuition option #1 - Tuition is due on the 1st each month (Tuition is considered late after the 6th)

( ) Tuition Option #2 - ½ due on the 1st of the month and ½ due on the 15th of the month (tuition is late after the 6th and 20th)

I also understand a $50.00 late fee will be assessed if my tuition is late.

I understand this schedule will be in effect throughout my child's attendance at Kindercourt unless requested in writing and approved by the school director. All schedule changes (adding or dropping a day or any other schedule change) are subject to availability and require 2 months written notice. I will also notify Kindercourt in writing, at least 2 months in advance, when leaving Kindercourt.

_____

Parent Signature Date

Kindercourt Academy 1225 Greenwood Ave San Carlos Ca 94070 591-4882
Kindercourt Laurel 1601 Laurel Street San Carlos Ca 94070 592-7980
Kindercourt San Mateo 211 So Delaware San Mateo Ca 94402 344-6612

Emergency Contact Numbers

Child's Name _____

Parent/Guardian #1 (First Name) _____

Cell phone _____

Email _____

Employer_____

Work Address _____

Work Phone _____

Parent/Guardian #2 (First Name) _____

Cell phone _____

Email _____

Employer_____

Work Address _____

Work Phone _____

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

LIC 700 (8/08)(CONFIDENTIAL)

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* MONTHS | BEGAN TALKING AT* MONTHS | TOILET TRAINING STARTED AT* 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-
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: PENINSULA REGIONAL OFFICE

   Licensing Office Address: 801 TRAEGER AVE, SUITE 100, SAN BRUNO, CA 94066

   Licensing Office Telephone #: (650) 266-8843

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.

KINDERCOURT ACADEMY
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: Community Care Licensing

ADDRESS: 851 Traeger Ave #360

CITY: San Bruno CA 94066

ZIP CODE:

AREA CODE/TELEPHONE NUMBER: 650 266 8843

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): Kindercourt

(PRINT THE ADDRESS OF THE FACILITY): 1225 Greenwood Ave SC 94070

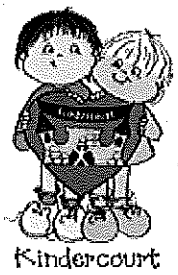
(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

LIC 613A (8/08)



Kindercourt Schools

Food Allergy Action Plan

**please fill this form out if your child is allergic to any foods and might have a reaction at school. If there are no known allergies, please recycle the form

Childs Name: _____

Extremely Reactive to _____

THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

After Epi pen is given, we will call you for further instructions, or 9-1-1 if the child is showing any signs of distress

==========

Mildly Reactive to _____

Reaction includes _____

Instructions for teachers :

Kindercourt Academy 1225 Greenwood Ave San Carlos Ca 94070 591-4882

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:

Vision:

Developmental:

Language/Speech:

Other (Include behavioral concerns):

Allergies: medicine:

insect stings:

food:

asthma:

other:

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.

Shot record must be completed by the doctor on THIS form. Please do not write "see attached".

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 Practioner

PARENTS:

Children need to have these shots before they can begin child care, kindergarten, and 7th grade.

Children entering child care should have:

Age When Enrolling:	Immunizations Required:
• 2-3 months	1 DTaP, 1 Polio, 1 Hep B, 1 Hib
• 4-5 months	2 DTaP, 2 Polio, 2 Hep B, 2 Hib
• 6-14 months	3 DTaP, 2 Polio, 2 Hep B, 2 Hib
• 15-17 months	3 DTaP, 3 Polio, 2 Hep B, 1 MMR*, 1 Hib**
• 18 months-4 years	4 DTaP, 3 Polio, 3 Hep B, 1 MMR*, 1 Hib**, 1 Varicella

* on or after the first birthday

** on or after the first birthday, regardless of any Hib doses given before the first birthday

Children entering kindergarten should have:

- 5 DTaP (4 doses meet requirement if at least one was given on or after the 4th birthday)
- 4 Polio (3 doses meet requirement if at least one was given on or after 4th birthday)
- 3 Hep B
- 2 MMR (both on or after 1st birthday)
- 1 Varicella

Children entering 7th grade should have:

- 3 Hep B
- 2 MMR (both on or after 1st birthday)
- 1 Varicella (2 doses are needed if immunized on or after 13th birthday)
- Td Booster (recommended)

See your child's doctor to make sure your child's immunization record has dates for these shots. You will need to show your child's yellow immunization record to register your child for child care and school.

CHILDREN'S EARTHQUAKE KIT

PLEASE INCLUDE EACH OF THE FOLLOWING IN A LARGE ZIP LOCK BAG:

**3 SNACKS (GRANOLA BARS, NUTS, FRUIT ROLL-UPS, CHEESE AND CRACKERS, ETC.)
**2 BOXES/CANS/BAGS/CONTAINERS OF JUICE OR WATER
**A PICTURE OF YOUR FAMILY OR YOUR CHILD WITH A FRIEND
**MINI FLASHLIGHT (OPTIONAL)
**SMALL BOOK, ANIMAL, TOY, ETC. (OPTIONAL)

PLEASE LABEL WITH YOUR CHILD'S NAME AND TEACHER'S NAME
BAGS ARE DUE WITHIN ONE WEEK OF ENROLLMENT, AND ARE MANDATORY FOR ALL CHILDREN.

PLEASE INCLUDE THE FORM AT THE BOTTOM OF THIS PAGE AND A SAFETY PIN IN YOUR KIT.

THANK YOU FOR YOUR COOPERATION!!

EMERGENCY RELEASE INFORMATION

Pupil _____
Address _____
Phone _____
Mother _____ Work# _____
Father _____ Work# _____

Medication Taken _____ Allergic to _____

IN CASE OF EMERGENCY, MY CHILD MAY BE RELEASED TO:

Name _____ Phone _____

Name _____ Phone _____

(To be filled out by school personnel if child is released)

Name _____
Released to _____
Location _____
Time _____ Date _____