

**Admission Agreement**

Child(ren)'s Name & Date of Birth \_\_\_\_\_

Mother/Guardian's Signature \_\_\_\_\_

Father/Guardian's Signature \_\_\_\_\_

	Home #	Cell #	Work #	Email for Invoices/School News
Mother/Guardian's				
Father/Guardian's				

\* NOTE: If parents are divorced or not living together and share custody, the initials of each parent are required.

**Parent Handbook**

I have received a copy of The Lincoln Learning Center's Parent Handbook. I have read and understand it's policies and procedures, and agree to comply with the program rules and regulations.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Services Offered**

At the Lincoln Learning Center, we provide children, a safe and secure learning environment that strengthens self-direction and encourages exploration. Under the teaching philosophy pioneered by Maria Montessori, the Lincoln Learning Center offers students freedom within a structured setting.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Admission Policies**

Children will be admitted and accorded equal treatment and access to services without regard to race, religion, color, national origin, or ancestry. The Lincoln Learning Center is for children ages two through five. The day your child turns two years of age they are eligible for our program. Children must be ready for the type of group experiences offered and able to benefit from the program. Our preschool is licensed for 48 children.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Enrollment**

The following forms must be completed and turned in to The Lincoln Learning Center BEFORE your preschooler may be admitted into the program: Copy of Admission Agreement, Health and History Report, Notification of Parents Rights, Personal Rights, Identification and Emergency Information, Consent for Emergency Medical Treatment, Physician's Report, and Immunization Requirements. Your child's spot at The Lincoln Learning Center will be held ONCE all paperwork is turned in and the \$75 non-refundable enrollment fee is paid.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Immunization Requirements**

Children must be immunized against Polio & Hep B (3 doses), DPT (4), MMR, Hib & Varicella (1), or have a statement on file giving a reason for exemption. The last TB test (if applicable) must have been within the past two years. Up-to-date immunization records must be presented at the time of enrollment.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Days and Hours of Operation**

The Lincoln Learning Center is open Monday through Friday, 7:00 a.m. - 6:00 p.m. Our half-day program is from 8:00 a.m. - 12:00 p.m. and our full day program is within the hours of operation.

\_\_\_\_\_  
( Initials)                      ( Initials)

**School Closings**

I understand that The Lincoln Learning Center will be closed on the following holidays mentioned in the Parent Handbook. There is no tuition credit or make-ups for these days.

- |                              |   |
|------------------------------|---|
| 1 Martin Luther King Jr. Day | 5 Independence Day & Day after (4th & 5th)  |
| 2 President's Day            | 6 Labor Day                                 |
| 3 Friday before Easter       | 7 Thanksgiving day and the following Friday |
| 4 Memorial Day               | 8 Winter Break ( Dec. 24th - Jan. 1st)      |

\_\_\_\_\_  
( Initials)                      ( Initials)

**Absences**

I understand that on a day that my child is unable to attend, it is my responsibility to notify The Lincoln Learning Center as soon as possible and that there will be no reduction in tuition fees for days missed.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Illness**

I understand that I will be contacted should my child become ill while at The Lincoln Learning Center. I agree to pick up my child promptly upon such notification. I also understand that my child cannot attend The Lincoln Learning Center on a day in which he or she is ill, as defined in the Parent Handbook.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Communicable Disease**

I understand that I must inform The Lincoln Learning Center within 24 hours, or the next business day after my child or any member of our immediate family has developed any communicable disease. I also understand that life threatening diseases must be reported immediately.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Sign-In / Sign-Out**

When dropping off your children, California law requires Sign-In / Sign-Out sheets. We become responsible when you sign in, and you assume responsibility when you sign out. You, as the adult, must sign your child in and out. You must use your full signature and not just initials.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Release of Child(ren)**

I understand that my child will be released only to myself, a legal guardian, the other parent (except where prohibited by court), and to those persons whose names I have listed on my child's Emergency Information Form. I understand that if someone other than my child's parents/guardians is to pick up my child on a specific day, I must notify The Lincoln Learning Center, even if they are listed on the Emergency Information Form. The designated person will be required to show a picture ID.

Please call us to get the guest gate code for that week.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Emergency Contacts**

I understand that I am required to maintain at all times, at least one additional emergency contact other than myself, including full names, home and work addresses, home and work phone numbers and cell phone numbers. I understand that in the event of an emergency for which I or my emergency contact cannot be reached, the staff may contact police or other emergency authorities.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Change of Information**

I understand that it is my responsibility to inform The Lincoln Learning Center of any changes to the information on the Emergency Information form, as well other forms in the admission packet, including but not limited to: address, home, cell and work phone numbers, medical conditions and pick-up authorizations.

\_\_\_\_\_  
( Initials)                      ( Initials)

**In the Event of an Emergency**

In the event of an emergency, if I cannot be reached, The Lincoln Learning Center has my permission to contact the physician(s) listed on my child's registration forms, or have my child transported to a local hospital for care. I will not hold the Lincoln Learning Center or its' employees liable. I understand that I am responsible for all expenses incurred.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Violent or Unsafe Behavior**

I understand that I may be contacted should my child display violent, unsafe, or continually inappropriate behavior. I agree to pick up my child promptly upon such notification.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Financial Policies**

**Enrollment Fees**

I understand that I must submit the one-time, non-refundable, non-transferable enrollment fee of \$75.00 before my child(ren) can attend the program.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Rates:** Please note during restrictions related to COVID-19 we do not have space for half day students.

Preschool Program 8:00 a.m. - 12:00 p.m.	
3 days/week	\$377/month
4 days/week	\$504/month
5 days/week	\$616/month

Full Day Program	
3 days/week	\$520/month
4 days/week	\$720/month
5 days/week	\$880/month

Children who are in diapers or potty training are an additional \$7/day, \$91/month for 3 days/week, \$126/month for 4 days/week and \$154/month for 5 days/week.

Monthly tuition and fees are based on an average of days:

3 days/week is considered 13 days of attendance monthly, 4 days/week is considered 18 days of attendance monthly, and 5 days/week is considered 22 days of attendance monthly.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Discounts**

We offer a 10% sibling discount to the lower tuition if one child is coming at least three full days per week.

We offer a 5% military discount to any child coming full days, copy of Parent/Guardian's ID required.

Only one discount can be used per family and is only applied to a full month's tuition and not other fees such as, potty training, late fees or extra days.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Tuition**

Tuition is due by the first of every month and late at the end of business on the 5th, 10% of the tuition due will be assessed for all late payments. If you have pre-arranged to make bi-monthly payments, the tuition will be split into two equal portions, or a late fee will be assessed to the remaining first half. The second half is due by the 15th and late on the 16th. A 10% late fee will be assessed. If a due date falls on the weekend or a holiday, the due date will be beforehand. Tuition two weeks in arrears will lead to dismissal from the school until the account is paid in full. Re-entering the program will be based on "space available" openings after the account is paid in full. Chronic late payment will lead to dismissal. Tuition is subject to change with a month's advance written notice.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Returned Checks**

Tuition checks returned by the bank are subject to a \$25 return check charge. If two checks are returned within a three month period, payment by cash or money order will be required.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Early Drop Off / Late Pick-Up Charge**

It is imperative that all parents pick up their children on time. The charge for the half day program is \$3 if your child is dropped off 5 minutes early, picked up 5 minutes late or a combination of both resulting in 5 minutes. After 1:00 p.m. the charge will be \$15. The charge for full day students is \$1.00 per minute starting at 6:01 p.m. and ends when you and your child exit the school's outside gate. Continued late pick-ups will result in termination of services.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Schedule Information**

**If a child is absent on their scheduled day(s) there is no substitution of days.**

**Illnesses**

There is no credit, refund or make-ups given in the event of an illness. If there is a severe illness ( of two weeks or more), arrangements may be made at the discretion of the Director.

**Changes in your Child's Set Schedule**

Any changes that are made by the parent/guardian during the actual month will become effective on the first of the following month. That means the tuition for the month will remain the same until the beginning of the next month. If you wish for your child's schedule to change for the next month, you must notify us at least two weeks prior to the beginning of that month in writing or in an email.

\_\_\_\_\_  
( Initials)                      ( Initials)

Enrollment for my child will begin on: \_\_\_\_\_ The hours of care are: \_\_\_\_\_ to \_\_\_\_\_  
(Date)

Their schedule will be (please circle): M T W Th F

**Withdrawal**

Children benefit most when the program and the home have a similar philosophy of teaching and discipline. Should the time arise when either The Lincoln Learning Center or the parent/guardian feels that the child is not benefiting from the program, or a change is occurring, either party may request withdrawal without prejudice with a two week written notice or email.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Drop-ins or Extended Care**

Drop-ins will be on a space available basis only. Please do not just show up, you will need to call or get preapproval to see if there is space available for that particular day. Please add \$2 to your child's daily rate. The cost to extend your child's day from 8 a.m.-12 p.m. to a full day is \$15.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Fees Specific to Your Child**

I understand that the monthly fee for my child to attend The Lincoln Learning Center will be based on the days enrolled per the attendance agreement. Any additional days will be added to my bill. I also understand that any changes to my child's set schedule must be submitted two weeks before the beginning of the month of change.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Rights of the Licensing Agency**

The Department of Social Services licensing department has the authority to inspect as specified in the Health and Safety Code Sections 1596.852, 1596.853, and 1596,8535. They have the right to interview children attending The Lincoln Learning Center, or staff without prior consent. This authority includes the right to inspect, audit and copy the child's records upon demand during normal business hours.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Pictures Taken at LLC**

I understand that any pictures I or other family members take at Lincoln Learning Center (ie. at holiday functions) may not be used on social media if there are other children in the picture. Lincoln Learning Center will only put pictures on our Facebook page that do not show the child's face.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Terms of this Admission Agreement**

This admission agreement is valid until the program or parents/guardians withdrawal the child with a two-week written notice and all fees are paid in full.

\_\_\_\_\_  
( Initials)                      ( Initials)

**Conditions of Termination**

As mentioned above The Lincoln Learning Center has the right to terminate this agreement and ask a parent/guardian to withdraw enrollment, if any of the following occurs:

On-going late pick up  
Repeated discipline problems  
Lack of parental cooperation

Inappropriate parental behavior to children, teachers or staff  
Chronic lack of payment  
The child presents a health or safety threat

\_\_\_\_\_  
( Initials)

\_\_\_\_\_  
( Initials)

I have read, understand and will comply with the policies and procedures included in the Admission Agreement and in The Lincoln Learning Center Parent Handbook.

Mother/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Father/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



**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
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**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
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**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?
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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*
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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  
( )

# 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
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### TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### 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](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### 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](http://www.meganslaw.ca.gov)*

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# 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

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**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.

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Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

## What to bring on your child's first day.

- A small lidless cup with your child's name on it.
- A change of seasonal clothes in a ziplock bag. This bag will be put in your child's cubby. If your child is potty training please bring several pairs of underwear and bottoms.
- A blanket and sheet if your child stays all day.
- If your child is in diapers or pull ups, please bring enough to last at least a week including wipes. Please put their name on the packaging.
- Please put your child's name on their lunch and any other personal items.

Thank you!