Check-off List for APS Admission

Child's Name ___________________ Date of Birth: _______

Start Date:________ Exit Date:_______

Licensing required paperwork (Left side of the file)

___ ID and Emergency Information
___ Consent for Medical Treatment
___ Preadmission Health History Report
___ Physician's Report
___ Immunization Record and TB test Waiver
___ Family Admissions Agreement
___ Parent's Rights
___ Personal Rights
___ I/T Needs and Services Plan

APS required paperwork (Right side of the file)

___ APS Directory Contact Sheet
___ Enrollment Agreement
___ Illness Policy
___ Family Needs Assessment
___ Emergency Binder Contact Sheet
___ Field Trip Permission Form
___ Media Release Form
___ APS Application

For Office Use Only:

Deposit Received ____ Check #______ Parent Handbook emailed ____ Google Groups: Community___Group____
Enrollment Packet emailed ____ New Child Transition Emailed ____ Added to Master Roster ____
App. Scanned Dep.Ck Sent ____ Parent Participation Card____

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
(   )

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?)

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

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: ______________________________
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.

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name ______________________ **Sex:** M ☐ F ☐ **Birthdate** ____________ **Place of Birth** ____________

Name of Parent or Guardian ______________________

Race/Ethnicity:
- ☐ White, not Hispanic
- ☐ Hispanic
- ☐ Black
- ☐ Other: ____________

Address ______________________

Telephone ______________________
Daytime Nighttime

City ______________________ **ZIP** ____________

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: ____________ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date ____________

Staff Signature ____________

Record Presented was:
- ☐ Yellow California Immunization Record
- ☐ Out-of-state school record
- ☐ Other immunization record
  Specify: ____________

II. STATUS OF REQUIREMENTS
- ☐ A. All Requirements are met.
  Date ____/____/____
- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
- ☐ C. Medical Reasons—Permanent
- ☐ D. Medical Reasons—Temporary
- ☐ E. Personal Beliefs

III. 7th GRADE ENTRY
- ☐ A. All Requirements are met.
  ____________ Name ____________ Date
- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.
  ____________ Name ____________ Date

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
   - A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
   - B. If the child has met all immunization requirements, check box A and write in date.
   - C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
   - D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
   - E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la comunidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) ______________________ Date (Fecha) ______________

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) ______________________ Date (Fecha) ______________

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

AQUATIC PARK SCHOOL
Family Admissions Agreement

This is an agreement between Aquatic Park School and ____
for the care of_________________________.

We agree to the following: (please initial each line.)

_________ **Tuition Policy:**
Monthly tuition is paid on the 1st or the 10th of each month. Tuition is paid via FACTS Management Co each month and payment plans are set up in advance for the school year. We will not raise our rates without a 30 day notice.

________ **Payments:**
Families set up payment plans with FACTS management company for the school year. There is a set up fee paid to FACTS annually that parents agree to pay (fee set by FACTS and approximately $43-$46 annual fee). A $25.00 late service charge will be assessed if your tuition payment is received late.

_______ **Parent Handbook** has been received and read.

_______ I have attended a **Child Needs/Family History Assessment** intake.

_______ I have been informed of the non-refundable **Enrollment/Staff Incentive fee** of $500 ($250 for sibling) and have paid this deposit.

_______ All forms required have been turned into the director.

_______ You will need to give a **30 day written notice** when canceling your child's enrollment. Aquatic Park School reserves the right to cancel any enrollment at any time.

_____ R**ights of Community Care Licensing of California (Section 101200 (b) and (c)**
The Department or Licensing Agency shall have the authority to interview children, or staff, and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any children or staff member; and for the examination of all records relating to the operation of this child care center. The Department has the authority to observe the physical condition of the child (children) including conditions that could indicate abuse, neglect, or inappropriate placement.

________ **Drop-in – Quote rate**.
We will take a child on their day off with a 24 hour notice if staffing is available. The cost of drop in care is $65.00 all day and $40.00 for half day.

Your monthly tuition rate is__________________________.

Your first payment is due____________________________.

Your pro-rated tuition for _____________ is ______________ and is due on ___________.

Enrollment Cancellation: **APS reserves the right to cancel the enrollment of a child for any of the following reasons:**

1. Nonpayment of tuition by the 15th of the month could result in termination of your child's enrollment.

2. Not observing APS rules and regulations.

3. Not completing and returning all required forms by the due date.

4. If a child has characteristics which make it difficult for the school to meet his or her needs.

5. If the child's attendance in any way violates California State Licensing requirements.

===

Keep this copy for your records and return the enclosed application for enrollment to APS.

Thanks!

Parent's Signature____Date________

Parent's printed name: _______________________________________

Staff Signature____Date________

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: ____

   Licensing Office Address: ____

   Licensing Office Telephone #: ____
8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (8/08) (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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee.____
Name of Family Child Care Home

Signature (Parent/Authorized Representative) ____Date____________________

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the 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)

Needs and Services Plan

(Infants and Toddlers Only)

The following is an infant needs and services Plan.   This plan will benefit the quality of care given to your child. This plan must be filled out completely and signed by the parent(s) prior to the enrollment of the child.

Feeding Plan

In accordance with this plan, the following is required

- Bottle fed infants are fed at least every four hours
- The staff may not prepare formula
- Bottles, containers of food, dishes etc. must be labeled w/ child's name
- The child may not carry a bottle/Sippy cup around while walking or standing
- Bottles used and unused, and uneaten food must go home at the end of day
- Honey and corn syrup will not be served

Feeding Schedule (please approximate)

7 am ____________________ 1 pm ____________________

8 am ____________________ 2 pm ____________________

9 am ____________________ 3pm ____________________

10 am ____________________ 4 pm ____________________

11 am ____________________ 5 pm ____________________

Noon ____________________ 6 pm ____________________

Other Information

Type of milk/formula ____

Food Allergies ____

____

Plan for introduction to foods ______________________________

____

____

Diapering Plan

My child uses:

______ Disposable Diapers

______ Cloth Diapers

______ Compostable Diapers

______ School wipes ______ Wipes from home

Sleeping Plan

I give the APS staff permission to put my child on their stomach in their crib. ______ Yes ______ No

Sleeping Schedule

7am	______	1pm	______
8am	______	2pm	______
9am	______	3pm	______
10 am	______	5pm	______
Noon	______	6pm	______

Parent(s) Signature ______________________ Date ______

______________________ Date ______

APS Directory Contact Sheet:

Child's Name: ______________________________

Parent/s Names: ______________________________

____

Home address: ______________________________

____

Home phone or Primary Cell:_________________________

Cell Phone #'s/work phone #'s (in order of preference to try first):

Name____________________Number ____________________________

Name____________________Number_____________________________

Name____________________Number_____________________________

Email addresses: Professional skills/interests/training:

________________ ________________________________

________________ ________________________________

________________ ________________________________

Parent Participation interests:

____

____

APS Illness Policy

This policy is designed to prohibit the spread of viral and contagious disease. It is imperative that every parent/guardian/teacher adhere to this policy to avoid the transfer of illness to other children, staff, and parents/guardians.

Please note that symptom free for 24 hours is defined as 24 hours from the time of last incidence of the symptom.

It is important to note that if your child is unable to play outside, they are too ill to attend school.

Conditions that prohibit your child from coming to school:	**Criteria for returning to school:**
Generally not feeling well Requiring total 1-on-1 Unable to participate in activities	Able to participate in all activities Exhibiting behavior typical of the child
Vomiting	24 hours since last occurrence
Diarrhea	24 hours since last occurrence
Fever of 100 degrees or over	Temperature normal for 24 hours
A severe or deep cough	Cough Free
Excessive mucus	Mucus production significantly reduced
Conjunctivitis (pinkeye)	If bacterial-Use of drops for 24 hours
Any contagious disease	Free of symptoms for 24 hours. If receiving antibiotics, must have been administered for 24 hours before returning.

Parent signature
of agreement_____________________________Date___________________

Aquatic Park School Emergency Contact Binder Sheet

Child's Name: _______________________________ Birthdate:____________________

Parent/Guardian: ____________________________ Daytime Phone:________________

Parent/Guardian: ____________________________ Daytime Phone:________________

Address:__________________________________ _Other Phone:_________________

City:_______________ Zip:_______________

Insurance Company:____

Policy Number:______________________ Name of Insured:_________________

Other Persons to Contact in and Emergency:

Name: ____________________ Phone:_______________ Relationship:_________

Name: ____________________ Phone:_______________ Relationship:_________

Name: ____________________ Phone:_______________ Relationship:_________

Physician:______________________________ Phone:_____________________

Child's allergies or other medical conditions:______________________________

____

____

____

Persons AUTHORIZED TO PICK UP MY CHILD:

Name: ____________________ Phone:_______________ Relationship:_________

Name: ____________________ Phone:_______________ Relationship:_________

Name: ____________________ Phone:_______________ Relationship:_________

I hereby authorize Aquatic Park School to obtain emergency treatment for my child. I understand that I am legally responsible for costs incurred for such treatments.

Print Name:____

Signature:____ Date:____________

Aquatic Park School

Field Trip Permission Form

I/We ____

The Parent(s)/Guardian(s) of ________________________

Understand and agree to the following (please initial each line)

_____ Field trips are periodically taken using various means of transportation

- Parent volunteers driving
- Van provided by the school
- Public Transportation
- Walking

We try and schedule these trips ahead and announce them in our monthly calendar. We are sometimes in a position to take in impromptu trip, or need to cancel due to staffing or transportation availability.

_____ Your child's participation in a field trip depends on several variables.

- Any limit set on the number of children who can attend because of driver availability, restrictions of location, or number of staff available.
- Child must have arrived at school no later than 9:00 am or the time that has been set for departure.
- Child's ability to follow the routine carefully and consistently, our destination and the age appropriateness of the trip will influence who is chosen for any field trip.

The staff at APS will have a list of children who are on the field trip, the route of travel and the destination on record here at the school, and available to you if necessary.

Your signature on this from will assure us that you have read, understand and agree to the above. Please check with your child's teacher if you have any concern.

Parent(s) Signature __________________ Date: ______________

__________________ Date: ______________

Aquatic Park School

Media Release Consent

I, ______________________________________ legal guardian/parent of

____ give Aquatic Park School permission to use my Child's photograph on the APS website, newsletter, brochure, public relations, documentation panels, preschool fairs and trainings. I understand that my child's full name will not be attached to the photographs, nor will the photographs be used or shared for any other purposes.

________________________________ Signature

________________________________ Date