BREA OLINDA UNIFIED SCHOOL DISTRICT
DEPARTMENT OF CHILD DEVELOPMENT SERVICES

PRESCHOOL REGISTRATION PACKET

ADMINISTRATIVE OFFICE

Arovista Elementary School - Room 28
(714) 990-7527

Early Learning Center Locations

Arovista Elementary School
Laurel Elementary School
Mariposa Elementary School
Olinda Elementary School
Country Hills Elementary School

A copy of your **child's immunization records and birth certificate is required to complete this packet. Please remember to attach these items.

Administrative Director: Penny Andrews
Supervisor: Meredith White
Administrative Assistant: Kayleen Farrer

Registration materials **must be received a minimum of two business days prior** to starting the program.

CHILD DEVELOPMENT SERVICES
BREA OLINDA UNIFIED SCHOOL DISTRICT

BREA OLINDA UNIFIED SCHOOL DISTRICT

DEPARTMENT OF CHILD DEVELOPMENT SERVICES

Preschool Registration Packet

Early Learning Centers

- ◯ Country Hills (Part-Time ONLY)
- ◯ Mariposa
- ◯ Olinda

Child's Name: _____ School Year: _____

* **ALL forms & payments must be received in order to enroll and start the program.** *

FOR OFFICE USE ONLY:

_____ Rate Sheet

_____ Admission Agreement

_____ Registration Form (ALL lines completed)

_____ BOUSD Data Enrollment Form

_____ BOUSD Language Questionnaire

_____ Authorizations Acknowledgement Form

_____ Identification/Emergency Information

_____ Personal Rights

_____ Parent's Rights

_____ Registration Fee

_____ Tuition Fee

MEDICAL FORMS:

_____ Birth Certificate

_____ Consent for Emergency Medical Treatment

_____ Parent's Health History

_____ Physician's Report (MUST be within 12 months of school entry)

_____ Immunization Record (MUST be official copy)

_____ Student Health Survey

_____ Screening Consent Form

_____ Participant Authorization Form

IF NEEDED:

_____ Medication Administration Form (if needed during school hours)

_____ Medication brought to School Readiness Nurse (before the 1st day of school)

ADMINISTRATIVE OFFICE

Arovista Elementary School - Room 28

(714) 990-7527

Administrative Director: Penny Andrews

Supervisor: Meredith White

Administrative Assistant: Kayleen Farrer

Program Technician: Jo Anne Warren

Early Learning Specialist: Amy Shultz

School Readiness Nurse: Anna Kim

Registration materials must be received a minimum of two business days prior to starting the program.

DEPARTMENT OF CHILD DEVELOPMENT SERVICES
PRESCHOOL RATE SHEET
2019-2020

- Registration Fee is $75.00 per child/$100.00 per family. Participants leaving the program for any length of time will be assessed the applicable Registration Fee upon return to the program.
- 1st month's tuition is due upon enrollment. **A 30-Day written notification** is required to cancel enrollment. Tuition will not be refunded or credited if proper written notification is not received 30-days prior to start.
- *Fees are based on year-round enrollment.* Prorated amounts will **not** be granted for non-school days (including furlough days) and fall/winter/spring recess. This includes part-time rate plans.
- Credit is not given for any day in which your child does not attend the program.
- Tuition is due the 1st of each month for the current month.
- The Department of Child Development Services is a self-sustaining program funded through parent fees.

Country Hills Early Learning Center - Half Day Program	**Monthly Fees**
A. Monday-Thursday, 8:00am - 11:00am	$375.00
B. Monday-Thursday, 11:30am - 2:30pm	$375.00

Mariposa Early Learning Center - Full Day Program	**Monthly Fees**
C. Monday-Friday, 7:00am - 6:00pm (Preschool Program + Extended Care)	$725.00

Olinda Early Learning Center - Full Day Program	**Monthly Fees**
D. Monday-Friday, 7:00am - 6:00pm (Preschool Program + Extended Care)	$725.00

I have read and understood the information stated above.

Check Enrollment Option: ☐ **A** ☐ **B** ☐ **C** ☐ **D**

_____ _____ _____
Child's Name Age School

_____ _____
Parent/Guardian Signature Date

_____ _____
BOUSD Representative Signature Date

900 Eadington Drive, Room 28 Brea, CA 92821 (714) 990-7527 Fax (714) 990-7528
Contact: Kayleen Farrer at (714) 990-7527 x 7537 or kfarrer@bousd.us

BREA OLINDA UNIFIED SCHOOL DISTRICT
Department of Child Development Services
Preschool Admission Agreement

As the parent or legal guardian of the below named child, I understand, agree to, and/or acknowledge the following:

A. I have reviewed a copy of the Parent Handbook and will comply with the policies set forth (handbook is available on the BOUSD website).

B. Field trips, either by walking or in BOUSD vehicles or chartered buses, are a part of Child Development program activities. No additional permission slips will be required.

C. BOUSD staff and volunteers are not allowed to babysit or transport children at any time outside of the BOUSD program.

D. I am not to leave my child at the BOUSD Program Center unless a BOUSD staff or volunteer is there to receive and supervise my child.

E. Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. (Please do not put staff in a position where they have to make this judgement call.)

F. BOUSD is mandated by state law to report any suspected child abuse or neglect to the appropriate authorities for investigation.

G. BOUSD may terminate my child's enrollment for any of the following reasons:
- Emergency names and phone numbers are incorrect.
- Parent or Guardian is late picking up child after the BOUSD Program Center closes.
- Non/Late/NSF payment of tuition fees.
- Failure to adhere to the sign-in/sign-out policies.
- Failure to notify the BOUSD Program Center that the child will be absent.
- Child leaving the BOUSD Program Center without authorized written permission.
- Behavior that is continually disruptive or dangerous to others and/or self.
- Behavior that is destructive to property and/or refusal to replace said property.
- Any single incident that is deemed by the Program Center Director to be dangerous, harmful or dangerous.
- Harassment, violent behavior or threat of such behaviors against a staff person or other member by parent/guardian or persons associated to the child (family member, family friend, etc.).

H. Program participation requires a BOUSD tuition in good standing. Non-payment of fees will result in my child not being allowed to participate in the program and could result in legal referral with additional costs to myself. I further understand that there is an administrative processing fee for any payment returned by my bank or credit account. Refunds and/or credits are not given for any day in which a child does not attend the program including school closures or seasonal breaks.

I. BOUSD and the staff employed by the BOUSD will not become involved in any custodial disputes between parent/guardian. If BOUSD documents are requested, the court must request them. The staff's responsibility is to provide a safe environment for children.

J. I understand that I am required to give a 30-day written notice when terminating from the BOUSD Child Development Program. If **30-day written notice** is not given, I will not receive a refund or credit. Registration fees are non-refundable.

K. The Community Care Licensing Division of California Department of Social Services (Section 101200) has 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 child(ren) or any staff member and for the examination of all records relating to the operation of the facility. The licensing agency has the opportunity to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect, or inappropriate placement.

Child's Name	Age	School

Parent/Guardian Signature	Date

BOUSD Representative Signature	Date

BREA OLINDA UNIFIED SCHOOL DISTRICT
PRESCHOOL REGISTRATION FORM

All spaces must be completed!

(Check One)
SCHOOL: Preschool ☐A ☐CH ☐L ☐M ☐O BIRTHDATE: _____

CHILD'S NAME: _____ ☐MALE ☐FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

FAMILY SURNAME: _____

PARENT/GUARDIAN #1: _____ ROLE: _____ CELL #:_____

PARENT/GUARDIAN #2: _____ ROLE: _____ CELL #:_____

ADDRESS: _____ CITY: _____ZIP CODE: _____

HOME PHONE #: _____ E-MAIL ADDRESS: _____

CHILD'S LEGAL GUARDIAN: _____ MARITAL STATUS: _____

CHILD LIVES WITH: _____
Are there any legal or custodial restrictions of which we need to be aware? ☐YES ☐NO
If yes, please attach a copy of the current custody order.
Would you like to be included in our Parent Directory? ☐YES ☐NO

PARENT/GUARDIAN #1 EMPLOYER: _____ ADDRESS: _____

WORK HOURS: _____ TO _____ TELE #: _____ EXT: _____

PARENT/GUARDIAN #2 EMPLOYER: _____ ADDRESS: _____

WORK HOURS: _____ TO _____ TELE #: _____ EXT: _____

PERSON TO CALL IN CASE OF EMERGENCY: _____ TELE #_____ (HM)
(NOTE: We will always call the parent/guardian first. Please list a "next best" person)
RELATIONSHIP TO CHILD: _____ TELE #_____ (CELL)
NAMES OF PERSONS AUTHORIZED TO TAKE YOUR CHILD HOME FROM CENTER - INCLUDE TWO PERSONS IN ADDITION TO THE PARENT(S)/GUARDIAN(S) (must be over 18 years of age). Your child will not be permitted to leave with any person without written authorization of parent or guardian.

_____
NAME ADDRESS TELEPHONE #

_____
NAME ADDRESS TELEPHONE #

PLEASE NOTE: In case of illness or accident at school when you are unable to contact me by telephone, I give my legal consent to have my child taken to the following physician:

FAMILY PHYSICIAN: _____ TELEPHONE #: _____

BREA OLINDA UNIFIED SCHOOL DISTRICT
PRESCHOOL REGISTRATION FORM (CONT'D)

All spaces must be completed!

UNIFORMED CONSENT: BREA OLINDA UNIFIED SCHOOL DISTRICT IS EXTREMELY PROUD OF ITS INSTRUCTIONAL PROGRAM IN ATHLETICS, PHYSICAL EDUCATION AND ACTIVITIES. EVERY PRECAUTION AND SAFEGUARD IS TAKEN TO INSURE THE SAFETY OF OUR STUDENTS. HOWEVER, PRECEDENTS SET BY RECENT LITIGATION HAVE CREATED A DEMAND IN SCHOOL DISTRICTS TO WARN STUDENTS OF THE RISK INVOLVED IN ATHLETIC/ACTIVITIES PARTICIPATION, AN INJURY, PARALYSIS, AND IN SOME **EXTREME** CASES, DEATH CAN OCCUR IN ANY ENDEAVOR. YOUR SIGNATURE ON THIS CARD INDICATES THAT YOU HAVE READ THIS STATEMENT.

DISASTER EVACUATION INSTRUCTIONS

In the event of a disaster, state law authorizes school authorities to release students to parents/guardians or other adults as approved by parents/guardians. Telephones may be useless in a disaster such as an earthquake, and you may be unable to come to school to obtain the release of your child. Therefore, please list other adults (neighbors, friends, etc.) who could come to school for your child. This list will **ONLY** be used in the event of a disaster evacuation. **In a disaster evacuation, my daughter/son may be released to any adult listed below:**

NAME:	**RELATIONSHIP:**	**TELEPHONE #:**
_____	_____	_____
_____	_____	_____

Name of out-of-state contact:_____ _____

Parent/Guardian Signature: _____

Grade Level _____

BREA OLINDA UNIFIED SCHOOL DISTRICT DATA ENROLLMENT FORM

Legal Last Name of Student	Legal First Name	Middle Name
Address (No., Street)	City Zip	Home Phone

Gender Male ☐ Female ☐	Birth Date	Birth City	Birth State	Birth Country
Prior Schools Attended (Name/District)			Phone	Dates Enrolled
Address			City	State Zip
Prior Attendance in Brea Olinda Unified School District? Yes ☐ No ☐			Dates Enrolled in BOUSD:	
U.S. Entry Date	First **USA** School Enter Date		First **California School Enter Date**	

Child is living with: ☐ **Father** ☐ **Mother** ☐ **Legal Guardian/Foster Parent** ☐ **Authorized Caregiver**

	Mark Appropriate Box: ☐ Father ☐ Stepfather ☐ Legal Guardian ☐ Foster Parent ☐ Caregiver	Mark Appropriate Box: ☐ Mother ☐ Stepmother ☐ Legal Guardian ☐ Foster Parent ☐ Caregiver
Name		
Address		
Home Phone	( )	( )
Cell Phone	( )	( )
Work Phone	( )	( )
Parent's E-Mail		
Parent Education Level	☐ (1) Not a high school graduate (Less than 12th grade)	☐ (1) Not a high school graduate (Less than 12th grade)
	☐ (2) High school graduate (Completed 12th grade)	☐ (2) High school graduate (completed 12th grade)
	☐ (3) Some college	☐ (3) Some college
	☐ (4) College graduate	☐ (4) College graduate
	☐ (5) Graduate school/Post graduate training	☐ (5) Graduate school/Post graduate training
	☐ (6) Decline to state	☐ (6) Decline to state

Ethnicity:

Is student Hispanic or Latino? ☐ Yes ☐ No

Please select race from the list below (check all that apply/must select at least one)

☐ American Indian/Alaska Native (100) ☐ Chinese (201) ☐ Japanese (202) ☐ Korean (203) ☐ Vietnamese (204)
☐ Asian Indian (205) ☐ Laotian (206) ☐ Cambodian (207) ☐ Other Asian (299)) ☐ Hawaiian (301)
☐ Guamanian (302) ☐ Samoan (303) ☐ Tahitian (304) ☐ Other Pacific Islander (399)
☐ African-American (600) ☐ White (700) ☐ Filipino (400)

If multiple races, please identify primary race: _____

My child receives the following services (*check all that apply)*

☐ Special Education (IEP)
☐ Resource Specialist Program (RSP) ☐ Special Day Class
☐ Speech and Language ☐ Other
☐ 504 Plan
☐ English Learner (EL)
☐ GATE

Retention:

☐ Yes (grade level____)
☐ No

Language child first spoke: _____ Language adult uses to speak to child: _____

Language child uses at home: _____ Language spoken by adults in home: _____

Current court papers (Custody, Restraining Orders, etc.) must be on file in the school office. Does this apply to your child? ☐ Yes ☐ No

SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE

Birthdates Verified: _____ Verification of Address: _____ Method: _____

Birth Certificate Number: _____ Date Entered: _____ Date Withdrawn: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Signature: _____ Date: _____

IS 159-2-12

BREA OLINDA UNIFIED SCHOOL DISTRICT

LANGUAGE QUESTIONNAIRE

LANGUAGE OTHER THAN SPANISH

(To Be Placed in Student's CUM LEP File)

Student's Name	ID Number	DOB
Primary Language	**Birthplace**	**US Enter Date**

	YES	NO
1. Has student been in school in another country? If yes, how long? _____	☐	☐
2. If yes, in what language was student being instructed? _____		
3. Has student been enrolled in another school (include pre-school) in the U.S.? If yes, what was the language of instruction? _____	☐	☐
4. Are there any older brothers or sisters living with student at home? If yes, indicate primary language spoken. _____	☐	☐
5. Can the student read, write, and do math in his/her primary language? If yes, at what estimated level? _____	☐	☐
6. Are books, magazines and/or television at home available in the primary language? If yes, does the student enjoy looking at them or reading them? _____	☐	☐
7. Are books, magazines and/or television at home available in English? If yes, does the student enjoy looking at them or reading them? _____	☐	☐
8. What language does student use when interacting/socializing with others who speak the same primary language? _____		
9. Did your child take the CELDT this year? Do you have the results? _____	☐	☐

The questions can be answered through the use of a translator that parents or school provides.

SS 270-2-08

Authorizations Acknowledgement Form

FORM A – **Annual Notice to Parent/Guardian**
I have received, read and agree to abide by the information stated in the ANNUAL NOTICE TO PARENTS/GUARDIANS.

Parent/Guardian Signature:_____ Date:_____

FORM B – **Media Release**
I give permission for my student to be featured in district issued publicity, including district publications, the district website and announcements (See MEDIA AUTHORIZATION FORM**).**

☐ Permission is NOT Granted. (Optional)

Parent/Guardian Signature:_____ Date:_____

FORM C – **Student Accident Plan**
I have read and acknowledge that the District DOES NOT provide Medical Insurance for student injuries, but does make Voluntary Student insurance available.

Parent/Guardian Signature:_____ Date:_____

FORM D – **Network Use Agreement**
My student understands and agrees to abide by the rules and obligations stated in FORM D when using computing devices, and to access BOUSD network resources.

Parent/Guardian Signature:_____ Date:_____

FORM E – **Pesticide Notice**
I have read the PESTICIDE NOTIFICATION and DO NOT wish to be notified beyond the published routine.

☐ I wish to be notified beyond the published routine. (Optional)

Parent/Guardian Signature:_____ Date:_____

FORM F – **Substance and Weapons Notice**
I have read and understand the penalties stated in the CONTROLLED SUBSTANCE/DANGEROUS WEAPON notification.

Parent/Guardian Signature:_____ Date:_____

FORM G – **Off Campus Permission**
I have read and understand the OFF CAMPUS TRIP PERMISSION FORM and give consent for my student to participate in off campus activities sponsored by the Brea Olinda Unified School District. As stated in Ed Code Section 35330, I understand that I hold BOUSD, its officers, agents and employees harmless from any and all liability or claims that may arise out of, or in connection with, my child's participation in this activity.

Parent/Guardian Signature:_____ Date:_____

FORM H-A – Student Health Survey
I have read and understand the STUDENT HEALTH SURVEY, and acknowledge that there is no other serious illness, injury, allergy, or other medical or physical problem than those already noted that would affect this student's performance and participation in school activities or PE.

Parent/Guardian Signature:_____ Date: _____

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

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

750 The City Drive, Suite 250

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Orange	92868	(714) 703-2800

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)

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: Community Care Licensing

   Licensing Office Address: 750 The City Drive, Suite 250, Orange CA 92868

   Licensing Office Telephone #: (714) 703-2800

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.

_____
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

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?)		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

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.

Brea Olinda Unified School District

Student Health Survey

Student Name: _____ **Birthdate:**_____ **Gender: M_____ F____**

School:_____ **Grade:**_____

If your student requires medication at school please provide the medication in the original pharmacy labeled container. If you are supplying over the counter medication please provide a brand new unopened bottle. A medication form with parent and healthcare provider signature must also be provided even for over the counter medication. These forms can be found on the school district website.

Does your student currently have:	YES	NO		YES	NO
Allergies (if yes, please list here) Life threatening_____			Hearing Problems/Deafness		
Asthma or Breathing Problems			Heart problems/High Blood Pressure		
ADD/ADHD			Hospitalizations (specify)		
Bladder problem			Lead Poisoning		
Bleeding problem			Muscle problems		
Bowel problem			Scoliosis		
Cerebral Palsy			Seizures		
Cystic Fibrosis			Sickle Cell Disease (not trait)		
Diabetes			Surgery (specify)		
Head or spinal injury/concussion (specify)			Vision Problems		

Brea Olinda Unified School District purchases and administers a variety of health products for students who may need minor medical attention. Unlicensed personnel may administer the products listed below. Please indicate the items you **DO NOT** authorize below.

Product	I DO NOT authorize the administering of the selected products.
BZK Towelettes (cleaning)	☐
Calamine Lotion (minor skin irritations)	☐
Cough Drops (grades 7 – 12 only)	☐
Vaseline for chapped lips, moisturizer	☐
Bee Sting Wipes (itch/pain relief)	☐
Eucerin/Lubriderm (for dry skin)	☐
Saline eye solution	☐

*Items are supplied by the school

Please sign the AUTHORIZATIONS ACKNOWLEDGEMENT FORM to indicate that you have read and acknowledge this form.

Brea Olinda Unified School District
Child Development Services Department – School Readiness Program

Child's Name _____ **Date of Birth**_____

Parent's Name _____ **Phone**_____

Parent Consent for School Readiness Health Screening

Brea Olinda Unified School District is providing the following services through the School Readiness Program. The screenings provided will assist School Readiness Nurses in identifying children who may need referrals for intervention. Your written consent is required for the nurses to conduct any of these screenings with your child. The School Readiness Nurse is also available to assist you if you are in need of health insurance and/or other community services. This screening is not intended to replace any medical evaluation. It has a limited scope and is not designed to uncover all problems. Brea Olinda Unified School District is not responsible for treatment or therapy for conditions uncovered by this screening.

Circle "yes" if you give consent for the screening or "no" if you do not consent for the screening.

- **Hearing Screening** **Yes** **No**
- **Dental Screening** **Yes** **No**
- **Vision Screening** **Yes** **No**
- **Height, Weight and Body Mass Index** **Yes** **No**
- Health information may be shared with appropriate school personnel. **Yes** **No**
- Health information concerning my child may be released to the appropriate agencies assisting in the care of my child and the school my child will be attending after preschool. **Yes** **No**

With my signature below, I give my consent for each of the screenings circled "yes" above. I understand that I will be provided with a written report if there are any concerns with the results of the screenings.

_____ _____

Parent Signature **Date**

Does your child have any health concern and/or allergies? **Yes** **No**
If yes, please list: _____

Does your child have a regular doctor or a "medical home"? **Yes** **No**

Does your child have medical insurance or medical coverage? **Yes** **No**

If yes, type of insurance: _____

If no, may we help you apply for medical insurance by sharing your contact information with a Medi-Cal Certified Application Assistant? **Yes** **No**

Does your child have a regular dentist or a "dental home"? **Yes** **No**

Does your child have dental insurance or dental coverage? **Yes** **No**

If yes, type of insurance: _____

Are your child's immunizations up-to-date? **Yes** **No**

If unsure of your child's immunization status, please call us and we can review the immunization record.

If you have any questions, please call our School Readiness Nurse at 714-990-7527 x5133.

The School Readiness Program is funded by a grant provided by
The Children & Families Commission of Orange County.

Children & Families Commission of Orange County

Brea Olinda Unified School District

Participant Authorization Form – Primary Caregiver and Child

As the parent or legal guardian of _____
(Child's name as listed on birth certificate) (First) (Middle) (Last)

I agree to allow (*BOUSD*) to share information about me and my child with the Children and Families Commission of Orange County, trusted organizations that are partners with the Commission, and Commission representatives. The information will be used to help the Commission learn how the services it funds help children prepare for school and to help plan for future services.

The information about both me and my child may include the following:

- Name, date and place of birth, gender, ethnicity, primary language, current address, services we received, results of the services received
- Medical information (medical/dental care utilization, birth weight, immunizations, etc.)
- Educational information (preschool services, special needs services, etc.)
- Developmental information (developmental screening, assessment, and services)

I understand that:

- I should answer only those questions with which I am comfortable -- I do not have to answer every question asked;
- Providing the information may involve a 10-minute interview when I start the program, when I complete the program and annually while I am receiving services from this program;
- Reports prepared from this information will not identify me or my child in any way;
- My approval to share this information will end on my child's nineteenth (19) birthday, and the information will be removed from the computer system. I also understand that I may cancel this authorization at any time by submitting a Request to Remove Confidential Information Form or by writing to *(BOUSD)* or the Children and Families Commission of Orange County at 17320 Red Hill Avenue, Suite 200, Irvine, California, 92614. My child may also cancel this authorization in writing when he/she is at the age in which the law allows him/her to act on his/her own;
- Signing this Authorization is voluntary; if I choose not to sign this Authorization, my child and I will **still** receive services from (*BOUSD*).
- This Authorization does **not** include sharing information that may identify me or my child related to participation in alcohol or drug treatment programs or criminal arrests or convictions. Such information may only be shared if I sign a separate, specific written consent form;
- The security and protection of my private information are very important to (*organization*). The only people who will be able to see my personal identifying information are those that provide me services and the Commission's

computer consultants, who need this information in order to delete and/or correct records. The Commission's staff and its partners who have access to our personal identifying information have signed an agreement to maintain its privacy.

- After some health information is shared it may no longer be protected by the Federal Privacy Rule, but may still be protected by other state and federal laws.
- A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this form if I ask for one.

Signature of parent or legal guardian: _____

Date: _____

Please print name clearly: _____

Relationship to child: _____

Child's birth date: _____

OR

☐ I do **not** want to share information about me and my child with the Children and Families Commission of Orange County, trusted organizations that are partners with the Commission, and Commission representatives. (Please check the box and fill out information below).

Signature of parent or legal guardian: _____

Date: _____

Please print name clearly: _____

Relationship to child: _____

Child's birth date: _____

Thank you!

FOR OFFICE USE ONLY

Name of Commission Funded Program: _____

Children & Families Commission of Orange County

CD103-3-16

Child Development Services Department-School Readiness Program
900 Eadington Drive, Room 28 · Brea, CA 92921 · (714) 990-7527 · Fax (714) 990-7528

BREA OLINDA UNIFIED SCHOOL DISTRICT

DEPARTMENT OF CHILD DEVELOPMENT SERVICES

TRANSPORTATION PASSENGER PROFILE

Participant's Name: _____

Site/Location Name:_____

Male ☐ ***Female*** ☐ **Height:**_____

Birthdate: _____ **Age:** _____

Please use only tape to attach or insert a photo of your student in this box.

CHILD DEVELOPMENT SERVICES

BREA OLINDA UNIFIED SCHOOL DISTRICT