



Required Enrollment Documentation

Parent's Name: _____ Child's Name: _____

Please provide the following documentation:

- Income for one Month** (Pay check stub, LES, Notice of Action or any sources of income)
3 months of income are required when there is any over time anywhere on the pay stub.
- Immunization Record**
- Copies of Birth certificate or vaccination record of All children (under 18 yrs) in household**
- Self –declaration of Income** (if necessary)
- California Residency** (A bill with name and address to prove CA residency)
- Foster Care Placement Records** If applicable
- Written Declaration of Job search** If applicable
- Declaration of Training towards Vocational Goal** If applicable
- Class schedule Form** If applicable
- Employer or Human Resources fax or e-mail address** to send employer verification form
- Self Employment Verification Form** If applicable
- Statement of Parental Incapacitation** If applicable. Must be completed by a physician.

Please complete, return and /or sign:

- Application for services for Child Development Services Form 9600**
- Notice of Action** completed by Program Director signed by parent Form 7617
- Physical Form LIC 701** completed by physician
- Preadmission Health History LIC 702**
- Children's Rights LIC 613**
- Parent's Rights LIC 995**
- Identification Emergency Information LIC 700**
- Consent for Emergency Treatment LIC 627**
- Meal benefit Form for Food Program CACFP**
- Tuition Schedule and Registration Enrollment Agreement**
- Emergency Card with authorized pick up**
- Tuition Commitment Letter**
- Consent for Photography**
- Termination Policy**

Documents are required by California Department of Education. Failure to provide the necessary documents will result in denial of services for your child.

Confidential Application for Child Development Services and Certification of Eligibility

Form ELCD 9600, Page 1, (REV. 12/19)

Agency Name: _____ FRPM Site
 Family Identification/Case No.: _____
 Initial Subsidized Service Date: _____
 Type of Application: (Check one) Initial Recertification

Note: State regulations require a formal application and certification for child development services. You will receive written notice of your eligibility no later than 30 days from the date of your signature on this form. This form must be completed by an agency representative in consultation with the family. The agency must verify and certify family eligibility prior to beginning services. **Refer to the attached instructions for the completion of this form.**

Section I. Family Identification. If you are a single parent/caretaker, check this box: **See Instructions, Section I.**

Name of parent/caretaker (full name, including middle initial) A.	Phone no. (cell or home)	Phone no. (work/school)
Name of parent/caretaker (full name, including middle initial) B.	Phone no. (cell or home)	Phone no. (work/school)
Street address	City	State
	Zip	FIPS code

Section II. Family Eligibility and Reason for Needing Service

A. Family Eligibility Status (Check as many as apply.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protective Services	Current Aid Recipient	Income Eligible	Homeless	Programs for the Severely Handicapped	CSPP Only-Qualified FRPM Resident				

B. Reason for Needing Service. Indicate all the reasons for needing care for each adult listed above. Enter "A" or "B" referring to parent/caretaker listed above. Attach documentation. (This section does not apply to part-day state preschool programs or programs for severely handicapped.)

Parent/Caretaker	Reason for Needing Service	Parent/Caretaker	Reason for Needing Service	Parent/Caretaker	Stages 1, 2, and 3 CalWORKs recipients only
	Homeless		Education or training		CalWORKs activities Date parent became ineligible for aid: _____
	Working		Actively seeking employment		Diversion Date: _____
	Child referred for protective services because of neglect, abuse, exploitation, or At-Risk thereof		Seeking permanent housing		Record date of entry into each stage: Stage 1: _____ Stage 2: _____ Stage 3: _____
	Parent/caretaker incapacitated because of medical or psychiatric special needs		CSPP Only - No Need Required		
			CSPP Only - FRPM Qualified Resident		

C. Employment/Training Information. Must be completed for each adult listed in Section I above to document need on the basis of employment or training. (Attach documentation.)

Parent/Caretaker	Employer/School	Street Address	City	Zip				
A								
A								
Days and working/training hours:	From: _____ To: _____	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Parent/Caretaker	Employer/School	Street Address	City	Zip				
B								
B								
Days and working/training hours:	From: _____ To: _____	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Section III. Family Adjusted Gross Monthly Income and Size

A. Family monthly income. The family's adjusted monthly income from all sources (Attach verification and documentation.): \$ _____
 B. Family income sources (Check all that apply. Do not count the gray shaded areas in Section III. A above.) **Black shaded boxes for CalWORKs recipients only.**

NOTE: Section III B is for federal data collection purposes only.

<input type="checkbox"/>	Employment, including self-employment	<input type="checkbox"/>	Other federal cash income programs (such as SSI)
<input type="checkbox"/>	Child support	<input type="checkbox"/>	Housing voucher or cash assistance
<input type="checkbox"/>	Cash or other assistance under Title IV of the Social Security Act (TANF)	<input type="checkbox"/>	Assistance under the Food Stamps Act of 1977
<input type="checkbox"/>	State-only alien and two-parent programs for CalWORKs recipients	<input type="checkbox"/>	Other: _____

C. Family size (See "Funding Terms and Conditions" for instructions on calculating family size.): _____

D. Parent(s) currently on active duty (i.e. serving full-time) in the U.S. Military? YES ___ NO ___

E. Parent(s) a current member of a National Guard or Military Reserve Unit? YES ___ NO ___



9467 Jamacha Blvd Spring Valley, Ca. 91977

Phone: 619.300.6964 Fax: 619.259.2879

Tuition Schedule and Registration Enrollment Agreement

I, _____ have agreed to enroll _____
 Parent or Guardian _____ Child's Name _____

During Higher Learning Academy's school year, I choose for my child to attend the following programs:

Full Day Program (please circle days needed)	M T W TH F	AM and/or PM
Half Day Program (please circle days and times needed)	M T W TH F	AM or PM
School Day Program (please circle days and times needed)	M T W TH F	AM or PM
Infant Center Program (please circle days and times needed)	M T W TH F	AM and/or PM

Tuition/Fees:

Full Day Program (over 4 hours) 2-5 year olds

- 2 Days Per Week: \$120.00/week
- 3 Days Per Week: \$180.00/week
- 4 Days Per Week: \$240.00/week
- 5 Days Per Week: \$300.00/week

School Age Program (Before & After School)

- 2 Days per Week: \$95.50/week
- 3 Days per Week: \$143.25/week
- 4 Days per Week: \$191.00/week
- 5 Days per Week: \$238.75/week

School Age Program (Full days vacation time)

- 2 Days Per Week: \$120.00/week
- 3 Days Per Week: \$180.00/week
- 4 Days Per Week: \$240.00/week
- 5 Days Per Week: \$300.00/week

Half Day Program (4 hours)

- 2 Days Per Week: \$90.00/week
- 3 Days Per Week: \$135.00/week
- 4 Days Per Week: \$180.00/week
- 5 Days Per Week: \$225.00/week

Infant Program (Birth-24 months)

- 2 Days Per Week: \$153.90/week
- 3 Days Per Week: \$230.85/week
- 4 Days Per Week: \$307.80/week
- 5 Days Per Week: \$384.78/week

Annual Registration: \$100.00 due upon registration.

All Tuition and fees are due according to enrollment agreement. Payment must be received in advance for the 1st week child is enrolled. **A \$25.00 late fee is assessed if payment is received later than agreement.** After two weeks of unpaid tuition a child's enrollment is discontinued. I further understand the first ten (10) days are probationary for Higher Learning Academy, parent and child. This agreement may be terminated at any time during that period. Thereafter a two (2) week notice, or equivalent payment, is required when the child is terminated from care.

- I understand that the registration fee holds a spot in the above class for my child and is **non-refundable**.
- As a courtesy, please notify Higher Learning Academy of your intention to withdraw your child at least two weeks in advance so that families on the waiting list can be notified on a timely basis.
- If a parent or guardian is late picking up a child after the 6:00 p.m. closing time, a \$25.00 late fee will be charged in 15 minute increments.
- Payment obligation is based on the hours you agree to use childcare, not on actual hours of attendance.
- If your child becomes ill endangering the health of other children it will be necessary for the parent/caretaker to make other arrangements for alternate child care.

I understand the above policies and procedures for enrollment and payment of tuition and fees agree to comply with the terms of this agreement.

Parent or Guardian

Date

Program Director /Executive Director

Date



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CHILD'S FULL NAME _____

BIRTHDAY _____

Mother's name

Father's name

Home # _____

Home # _____

Work # _____

Work # _____

Cell # _____

Cell # _____

Email: _____

Email: _____

Persons authorized to pick up child: Must be over the age of 16 and show valid I.D.

Name

Phone number

_____	_____
_____	_____
_____	_____
_____	_____

Allergies / Special Notes: _____

Parent or Guardian Signature

Date



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Tuition Commitment Letter

I, _____ have agreed to enroll _____ starting on _____
 (Signature (Parent or Guardian) (Child's Name) (Date)

- Annual registration fee is \$100.00 per child and is due upon registration. This registration fee is non-refundable.
- Late Fee for Pick Up after 6 pm: \$25.00 amount will increase in increments of 15 minutes.

Enrollment Schedule:	<input type="radio"/> Full Day (Over 4 Hours)	<input type="radio"/> Half Day (Less than 4 hours)
<input type="radio"/> School Day (8:30-11:30 am / 3-6 pm)	<input type="radio"/> Extend Care	<input type="radio"/> Infant Center
Circle the Days of Attendance:	M Tu W Th F	
Circle Time of Attendance if Applicable:	AM or PM	
Discounts:	<input type="radio"/> Military - 10%	<input type="radio"/> Sibling- 10%
Program	<input type="radio"/> NACCRRRA	<input type="radio"/> YMCA
	<input type="radio"/> CDA	<input type="radio"/> PCG
		<input type="radio"/> CSPP

I agree to pay _____ dollars the first day of each month. ()

I agree to pay _____ dollars every week of each month. ()

I agree to pay _____ dollars biweekly of each month. ()

I agree to pay _____ dollars the last week of each month. ()

I agree to pay the co-payment _____ dollars the first day of each month. ()

I, THE UNDERSIGNED DO UNDERSTAND THAT A \$ 25.00 dollar late fee is assessed after nonpayment of tuition. After two weeks of unpaid tuition a child's enrollment is discontinued.

SIGNATURE
 (PARENT/AUTHORIZED REPRESENTATIVE): _____ Date: _____
 EXECUTIVE DIRECTOR/PROGRAM DIRECTOR: _____
 Date: _____



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Consent Form for Photography and Images of Children

Dear Parent,

During your child's life at Higher Learning Academy we may wish to take photographs of activities that involve your child. The photographs may be used for school displays, or presentations. The result is that we are unable to celebrate children's work and activities in the way that we would like. As you know, photography can be a powerful tool for children's learning and forms an interesting and exciting visual record of work and events. We are actively encouraged to take photographs for assessment purposes, and pupils should also be encouraged to take digital images for their ICT work.

When we display photographs in school, we will only photograph and no names. Should we wish to use an image of your child on our website or in a school publication, we will contact you to receive your express permission. The photographs we take will be archived periodically, but may be used for presentations or special occasions. We will soon be publishing a leaflet to give guidance to children and parents who wish to photograph school events and activities.

Photography will only take place with the permission of the Director / Lead Teacher, and under appropriate supervision. Images that might cause embarrassment or distress will not be used nor will images associated with material on issues that are sensitive.

Before taking any photographs of your child, we need your permission. Please answer the questions below, sign and date the form and return it to school as soon as possible. You can ask to see images of your child held by the school. You may withdraw your consent at any time by informing the school in writing.

Name of child (Block Capitals) :					
Name of person responsible for the child:					
<p>I understand that:</p> <ul style="list-style-type: none"> • staff, pupil or professional photographers acting on behalf of the school may take images for use in displays and presentations • the school will contact me if they wish to use my child's image in a school publication or on their website; • the local media may take images of activities that show the school and children in a positive light e.g. Reception Year pictures of new starters, drama and musical performances, sports and prize giving; • embarrassing or distressing images will not be used; • the images will not be associated with distressing or sensitive issues; and • the school will regularly review and delete unwanted material. 					
Having read the above statement, do you give your consent for photographs and other images to be taken and used? (please tick the appropriate box)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"></td> <td style="width: 50%; border: none;">YES, I give my consent for pictures to be taken and used</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">NO, I do not give my permission for pictures to be taken and used</td> </tr> </table>		YES , I give my consent for pictures to be taken and used		NO , I do not give my permission for pictures to be taken and used
	YES , I give my consent for pictures to be taken and used				
	NO , I do not give my permission for pictures to be taken and used				
Signature of person responsible for the child:					
Relationship to the child:					
Date (Date/Month/Year):					



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Termination Policies:

We reserve the right to terminate a child for the following reasons (but not limited to):

- Failure to pay
- Routinely late picking up your child
- Failure to complete the required forms
- Lack of parental cooperation
- Failure of child to adjust to the center after a reasonable amount of time
- Physical or verbal abuse of any person or property
- Our inability to meet the child's needs
- Lack of compliance with handbook regulations
- Serious illness of child
- Behavior issues that threaten his/her or others safety.

We appreciate as much advance notice as possible when terminating, and we will give the same courtesy in return. Parents are required to give two weeks written notice when they decide to terminate child care. The two weeks will be paid in full regardless of whether or not the child is in attendance.

The provider reserves the right to give written notice of immediate termination where there are extreme circumstances that affect the well-being of the provider of other children in attendance.

Anyone who terminates daycare and has a balance that is outstanding will need to have the account settled within 30 days. All accounts not settled within 30 days will be turned over to a collections agency regardless of amount owed. All accounts turned over to collections will have a \$25.00 per week late fee plus 45% collections fee added to amount due.

Revisions to Handbook and Contract

We reserve the right to make changes in rates and policies as we deem necessary. You will be notified in writing of any changes that may occur. Every attempt will be made to give at least two weeks notice of changes.

Parents/Guardian's Signature (indicating receipt)

Date

Signature of Administrator

Date

PERSONAL RIGHTS**Child Care Centers**

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

7575 Metropolitan Dr., suite 110, MS 29-20

CITY

San Diego

ZIP CODE

92108-4421

AREA CODE/TELEPHONE NUMBER

(619) 767-2300

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)

Higher Learning Academy

(PRINT THE ADDRESS OF THE FACILITY)

9467 Jamacha Blvd. Spring Valley, 91977

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Higher Learning Academy

FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

NAME

. THIS CARE MAY BE GIVEN UNDER

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
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME		LAST	MIDDLE	FIRST	BIRTHDATE	
HOME ADDRESS		NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME		LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS		NUMBER	STREET	CITY	STATE	ZIP
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
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**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)
Higher Learning Academy _____ . This Child Care Center/School provides a program which extends from 06 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to 6:00 a.m./p.m. , 5 _____ 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)	/ /	/ /	/ /	/ /	/ /
M/MR (MEASLES, MUMPS, AND RUBELLA) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (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.

CHILD'S PREADMISSION HEALTH HISTORY--PARENT'S REPORT

CHILD'S NAME _____

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME _____ SEX _____ BIRTH DATE _____

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME _____ DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? _____

IS/HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? _____ DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? _____

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only) _____ DATE OF LAST PHYSICAL/MEDICAL EXAMINATION _____

WALKED AT* _____ MONTHS _____ BEGAN TALKING AT* _____ MONTHS _____ TOILET TRAINING STARTED AT* _____ MONTHS _____

PAST ILLNESSES -- Check illnesses that child has had and specify approximate dates of illnesses:

<input type="checkbox"/> Chicken Pox	DATES	<input type="checkbox"/> Diabetes	DATES	<input type="checkbox"/> Poliomyelitis	DATES
<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? 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	WHAT ARE USUAL EATING HOURS?
LUNCH	BREAKFAST _____
DINNER	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 _____

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: 7575 Metropolitan Drive, 109

Licensing Office Address: San Diego, CA 92108

Licensing Office Telephone #: 619-767-2300

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.

Higher Learning Academy
Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov



SAN DIEGO COUNTY
OFFICE OF EDUCATION

Dear Parent:

Did you know that your child is enrolled in a preschool that is participating in the First 5 San Diego Quality Preschool Initiative? Yes, your child is enrolled in a preschool that is committed to continually improving its quality according to state and national experts in the field of early childhood education.

The Quality Preschool Initiative is managed by the San Diego County Office of Education and funded by First 5 San Diego. This partnership is committed to eliminating the achievement gap by providing high-quality early education experiences to children.

The purpose of the Quality Preschool Initiative is to build an effective system for delivering high quality preschool experiences to children and families that:

- Utilizes well-qualified teachers and staff with specialized training in early childhood education.
- Provides eager young learners with academic and social skills that prepare them to be successful learners in kindergarten.
- Utilizes a research-based curriculum that is developmentally appropriate and sets goals specific to pre-k.
- Builds trusting relationships with families by respecting and supporting home language, exchanging information about the child, and engaging families in classrooms.
- Includes children with special needs.

The Quality Preschool Initiative is also working to help connect children and families with other available services in the community to promote the health and well-being of families in San Diego County. Please ask your preschool provider about any services that may be available to you.

If you have any questions about the Quality Preschool Initiative, please call us at (858) 292-3700. Enjoy a wonderful year with your child.

Sincerely,

Lucia Garay
Executive Director
Early Education Programs and Services
San Diego County Office of Education



SAN DIEGO COUNTY OFFICE OF EDUCATION

6401 Linda Vista Road, San Diego, CA 92111 • 858-292-3500 • www.sdcoe.net
Interim San Diego County Superintendent of Schools Edward Velasquez

Dear Parent(s):

Your preschool receives grant funds from local and state resources in order to operate. As a condition of funding, we are required to participate in research and evaluations, and provide information regarding operations to the agency providing the funding, so they may evaluate program effectiveness. By signing the "Consent to Participate" forms (attached), you are authorizing your Quality Preschool Initiative Preschool Provider to share certain evaluation data regarding your child with the San Diego County Office of Education ("SDCOE"), First 5 San Diego, and First 5 California for up to ten (10) years.

The evaluation data that your Quality Preschool Initiative Preschool Provider may share includes the following:

- Assessment results from the Desired Results Developmental Profile, which is completed by your child's teacher and measures your child's development.
- Screening results from the Ages and Stages Questionnaire, which is completed by you and staff at our agency to screen for developmental delays.
- Whether or not your child receives specialized services through an Individualized Education Program (IEP).
- Your child's ethnicity and primary language.
- Information regarding referrals concerning supports for your child's development.

Your child's name and personal information will never be release to the public or made available for public viewing. The agencies that fund your child's preschool comply with strict laws requiring them to keep your child's information private, similar to SDCOE. If you sign the attached forms, your preschool may also share directory information including your child's name, gender, date of birth and dates of attendance. Your preschool does not need parent consent in order to share this information, unless you have opted out of release of directory information.

Even if you provide consent by signing and returning the enclosed forms, you may withdraw your consent at any time thereafter. Providing your consent at this time does not limit your ability to withdraw your consent to participate in the research evaluation in the future. If at any time after providing your consent, you choose to withdraw your consent to share evaluation data with the funders, please contact your Quality Preschool Initiative Preschool Provider for the requisite forms.

If you agree to participate in the evaluation process, please sign the attached form(s) and return them to your Quality Preschool Initiative Preschool Provider. If you do not agree, please draw a line through the attached form(s) and write "no" in the signature line and return to your Quality Preschool Initiative Preschool Provider. If you should have any questions or concerns, please contact me.

Sincerely,

Lucia Garay
Executive Director
Early Education Programs and Services
San Diego County Office of Education



AUTHORIZATION FOR USE OR DISCLOSURE OF STUDENT INFORMATION TO AND FROM PRESCHOOL AGENCIES

Completion of this document authorizes the disclosure and/or use of personally identifiable student information between your child's preschool, San Diego County Office of Education and First Five 5 San Diego, as set forth below, consistent with California and Federal laws concerning the privacy of such information and use of non-identifiable student information between First 5 San Diego and First 5 California for the purposes of program study and funding. If you consent to disclosure of information as described herein, please fill out, sign and return this form to: _____.

USE AND DISCLOSURE INFORMATION RELATED TO:

Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize the above named Student's preschool, _____, and San Diego County Office of Education, 6401 Linda Vista Road, San Diego, CA 92111, to exchange information regarding the above named Student with First 5 San Diego and First 5 California. The information is exchanged for program evaluation purposes and for preschool, programming and service planning. The exchange of information is a condition on which funding for the preschool program is provided to San Diego County Office of Education. The information will be exchanged between your child's preschool, San Diego County Office of Education and First 5 San Diego for the purpose of providing safe, appropriate, and least restrictive education settings and quality preschool health services and programs. Aggregate non-identifiable student information between First 5 San Diego, and First 5 California for the purpose of program study and funding.

Requested information shall be limited to the following: your child's ethnicity, primary language and results from Screening Tools: ASQ-3 and ASQ-SE/Developmental Assessment: DRDP-PS/Special Needs (IEP/IFSP), Referrals for support services.

DURATIONS

This authorization shall become effective immediately and shall remain in effect until _____ or one year from today.
Date

RESTRICTIONS ON RE-DISCLOSURE

California law prohibits the requestor from making further or additional disclosure of private information to another third party unless the requestor obtains another authorization from you, or the disclosure is specifically required or permitted by law.

YOUR RIGHTS

You have the following rights with respect to this authorization, and affirm you understand them in signing this release form. You may revoke this authorization at any time by submitting written revocation signed by you or your representative and delivered to the agency/persons listed above. Your revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization. You have the right to receive a copy of this authorization.

Signing this authorization may be required in order for this student to obtain appropriate/additional specialized support services in the educational setting.

Approval: _____
Printed Name Signature Date

Relationship to Student

Area Code and Telephone Number