# Confidential Application for Child Development Services and Certification of Eligibility

Form EESD 9600, Page 1, (REV. 9/17)

Agency Name: _____
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.)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Protective Services | | Current Aid Recipient | | Income Eligible | | Homeless | | Programs for the severely handicapped |

### 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 | | | | | |

### 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.**

| | | | |
|---|---|---|---|
| | Employment, including self-employment | | Other federal cash income programs (such as SSI) |
| | Child support | | Housing voucher or cash assistance |
| | Cash or other assistance under Title IV of the Social Security Act (TANF) | | Assistance under the Food Stamps Act of 1977 |
| | State-only alien and two-parent programs for CalWORKs recipients | | 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 ___
Parent(s) a current member of a National Guard or Military Reserve Unit? YES ___ NO ___

# Confidential Application for Child Development Services and Certification of Eligibility



**Section IV. Data on Children.** List **ALL** children residing in the home and counted in the family size.

| *Complete for all children residing in the home* | | | *Complete only for children served by your agency* | | | | | *For children enrolled in more than one program or site, use additional lines as needed* | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (1) Full Name of Child Including Middle Initial | (2) Gender M | (2) Gender F | (3) Birth Date MM/DD/YYYY | (4) Adjustment Factor Code | (5) Ethnicity | (6) Race | (7) Native Language: Language Code | (7) Native Language: Child is English Learner? (School age ONLY) | (8) Program Code | (9) Type of Care Code | (10) Hours of Care per Day | M | T | W | T | F | S | S |
| | | | | | | | | | | | S | | | | | | | |
| | | | | | | | | | Provider/site name: | | V | | | | | | | |
| | | | | | | | | | | | S | | | | | | | |
| | | | | | | | | | Provider/site name: | | V | | | | | | | |
| | | | | | | | | | | | S | | | | | | | |
| | | | | | | | | | Provider/site name: | | V | | | | | | | |
| | | | | | | | | | | | S | | | | | | | |
| | | | | | | | | | Provider/site name: | | V | | | | | | | |
| | | | | | | | | | | | S | | | | | | | |
| | | | | | | | | | Provider/site name: | | V | | | | | | | |

**Section V. Certification and Signature of Parent/Caretaker.**

1. I understand that I am self-certifying single parent status under penalty of perjury in Section 1 of this document when the single parent/caretaker box has been checked. Parent Initials: _____

2. I understand that the information about my eligibility may be reviewed by representatives of the State of California, the federal government, independent auditors, or others as necessary for the administration of the program.

3. I understand that if the agency denies this application for services, I have the right to appeal.

4. I understand that I will receive a notice of approval or disapproval of my application within 30 days from the date I sign this form.

5. I understand that this certification is not complete until all documentation is submitted and this form has been signed and dated by me and reviewed, signed, and dated by an agency representative.

6. I certify that my family assets do not exceed $1,000,000; Child Care and Development Block Grant Act Section 658 p (4)(B).

7. I understand that I must renew my eligibility at least once a year. I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized child care services for my child.

***I DECLARE UNER PENALTY OF PERJURY THAT THE ABOVE INFORMAITON IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.***

| Signature | Date | Relationship to Child: ☐ Parent ☐ Grandparent ☐ Guardian ☐ Foster Parent ☐ Other: Please describe _____ |
|---|---|---|
| Signature | Date | Relationship to Child: ☐ Parent ☐ Grandparent ☐ Guardian ☐ Foster Parent ☐ Other: Please describe _____ |

**Section VI. Family Fee** (Refer to the current CDE Family Fee Schedule).

| Type of Fee | Flat Monthly Fee Rate (See the instructions for Section VI.) | |
|---|---|---|
| ☐ Full-time<br>130 hours or more per month | Flat Monthly Rate:<br>$ | Specifics: |
| ☐ Part-time<br>Under 130 hours per month | Flat Monthly Rate:<br>$ | Specifics: |

**Section VII. For Office Use Only.** ***(Certification is not complete until eligibility is reviewed, signed, and dated by an agency representative.)***

| Eligibility Status: ☐ Accepted ☐ Denied | Date Notice of Action Sent (Attach copy) | Date Notice of Action Given (Attach copy) | First date of subsidized service | Last date of enrollment |
|---|---|---|---|---|
| Signature of Authorized Agency Representative | | Title | Telephone number | Date |
| Signature of Supervisor (Optional) | | Title | Telephone number | Date |

**Shingletown Early Childhood Learning Center**
**State License Number 455401754**
**7946 Ponderosa Way**
**Shingletown, CA 96088**

_____ _____

**Name of Parent / Guardian** **Date**

I am interested in more information about:

***Parenting and Counseling***

___ Teenage Parenting

____ N.V. Catholic Services

___ Shasta Co. Special Education

___ Shasta Co. Mental Health

___ Family Resource Network

***Health***

___ Shasta Co. Heath Dept.

___ CHDP (Child Health & Disability Prevention)

___ Medi-Cal

___ Mercy Maternity Clinic/Med. Clinic

___ Salvation Army

___ Redding Area Bus Authority

***Chemical Dependency***

___Shasta Co. Substance Abuse

___Trinity House (Day treatment)

___ Empire Recovery House (Residential)

___Alcoholics Anonymous

___ Narcotics Anonymous

___ Crossroads Clinics

___ Redding Specialty Hospital

***Domestic Violence***

___ Battered Women

___ Rape Crisis / Women's Refuge

___ Child Abuse Hotline

***Financial Assistance***

___AFDC (Aid to families with Dependent Children

___ Salvation Army

___ Social Security Income

***Shelter and Housing***

___ Open Arms, Inc.

___ People of Progress

___ Salvation Army

___ Shasta Housing Authority

___ Women's Refuge

___ Aid (To families with Dependent Children)

***Food and Clothing***

___ WIC (Women, Infants)

___ People of Progress

___ Open Arms, Inc.

___ Food Stamps

___ Salvation Army

___ Anderson/Cottonwood (Christian Assistance)

California Department of Education
Early Education and Support Division
CD-9607 (Rev. 09/2005)

To be completed by parent or guardian and updated at recertification and as changes occurs.

# Emergency and Identification Information

## I. Family Information

Child's name (Last, First, Middle): _____ Birth Date: _____

Mother's name: _____

Father's name: _____

Child's Address: _____ Phone: _____

Mother's business address: _____ Phone: _____

Father's business address: _____ Phone: _____

## II. Names of Persons Authorized to Take Child from the Facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

| Name | Telephone | Relationship |
|---|---|---|
| | | |
| | | |

## III. Additional Persons Who May Be Called in an Emergency to Take Child from the Facility

| Name | Address | Telephone | Relationship |
|---|---|---|---|
| | | | |
| | | | |

## IV. Physician to Be Called in an Emergency

Name _____ Telephone _____

Address _____

## V. Medi-Cal Number _____ Medical Insurance _____

**Insurance Number** _____

## VI. Allergies or Other Medical Limitations _____

## VII. Permission for Medical Treatment

Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

*In case of an accident or an emergency, I authorize a staff member of the child development agency to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.*

Signature _____ Date _____
Parent or Guardian

CALIFORNIA DEPARTMENT OF EDUCATION
Form CD 9600A, (Rev. 01/04)

## Child Care Data Collection
## Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who receive child care assistance. The information will be reported to the California Department of Education (CDE) and then to HHS. The information will be used for research on the status of child care in the United States and will provide valuable data to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, the Legislature, other governmental agencies, or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the Social Security Number of the head of the family unit receiving child care assistance. If you do not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated in Section 98.71(a)(13) of *Title 45* of the *Code of Federal Regulations*, *Education Code* Section 8261.5, and Section 18070 of *Title 5* of the *California Code of Regulations*. Your decision to provide your Social Security Number is voluntary.

I have been informed of the way my Social Security Number will be used. I understand that if I do not wish to give my number, I can still receive child care assistance.

☐ YES, my Social Security Number may be used: _____-_____-_____

☐ NO, I do not wish to give my Social Security Number for this purpose.

_____ _____
Signature of the Head of Household Date

_____
Type or Print Name

You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Early Education and Support Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

# 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 |
|---|---|

As the parent, agency representative, or legal guardian, I hereby give consent to **SHINGLETOWN EARLY CHILDHOOD LEARNING CENTER** to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.), osteopath (D.O.) or dentist (D.D.S.) for:

_____

Child's Name

This care may be given under whatever conditions are necessary to preserve the life, limb or wellbeing of my dependent.

My child has the following medication allergies:

_____

_____

_____

_____ _____

**Date:** **Parent/Agency representative/Guardian Signature**

| |
|---|
| Home Address: |
| Home Telephone: |
| Work Telephone: |

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

# PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m., _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: 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

# 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: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

***NOTE:*** ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

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

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***

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY

DEPARTMENT OF Social SERVICES
COMMUNITY CARE LICENSING

# NOTIFICATION OF PARENT'S RIGHTS

## INSTRUCTIONS:

This form is intended to meet the requirement of California Health and Safety Code Section 1596.87 which requires that parents or guardians be informed of their right to enter and inspect the child care facility where their child is receiving care. The facility is required to:

1. Post this statutory right in a prominent place in the facility that is easily accessible to public view.
2. Complete and detach the form at the perforated portion.
3. Give the parent or guardian the top portion of this form.
4. File and maintain the detached bottom portion in the child's facility record to document that all parties have been notified of this right in accordance with the above statute.

## Parent's Rights

1. Parents/guardians, upon presentation of identification, have the right to enter and inspect the child day care facility, in which their child(ren) are receiving care, without advance notice to the provider. Entry and inspection right is limited to the normal operating hours while their child(ren) is receiving care.
2. The law prohibits discrimination or retaliation against any child or parent/guardian for exercising his/her right to inspect the facility.
3. The law requires that parents/guardians be notified of their rights to enter and inspect.
4. The law requires that this notice of parent's rights to enter and inspect be posted in the facility in a location accessible to parents/guardians.
5. The law authorizes the person in charge of the child day care facility to deny access to a parent/guardian. under the following circumstances:
   a) The parent/guardian is behaving in a way which poses a risk to children in the facility.
   b) The adult is a noncustodial parent and the facility had been requested in writing by the custodial parent not to permit access to the non custodial parent.

LIC995(1/90) DETACH HERE

## ACKNOWLEDGEMENT OF PARENT' RIGHTS NOTIFICATION

This will acknowledge that I/we, the parent(s) of _____,have received a copy of

"PARENT'S RIGHTS"

From the licensee or authorized representative of the SHINGLETOWN EARLY CHILDHOOD LEARNING CENTER.

_____ _____

Signature of Parent(s)/Guardian(s) 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:

DEPT. OF SOCIAL SERVICES, HEALTH & WELFARE AGENCY

NAME

COMMUNITY CARE LICENSING

ADDRESS

520 COHASSET ROAD, SUITE 6

| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
|---|---|---|
| CHICO , CA | 95926 | |

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) |
|---|---|
| | |

# SHINGLETOWN EARLY CHILDHOOD LEARNING CENTER
# ADMISSION POLICY

Shingletown Early Childhood Learning Center accepts any child ages 3-5 years of age, who is potty trained and physically and emotionally ready for the type of group experience the Center has to offer, without regard to race, sex, or ethnic background.

The following will be required before a child may enter his/her first day at: SECLC

- Parent interview with Director.
- Child health history form completed.
- Complete immunization records submitted and kept on file.
- Emergency forms completed.
- Physician's Report completed in on file in the office within thirty (30) days after enrollment.

## WHAT TO BRING

- All children should have an extra set of clothing labeled with his/her name.
- Children needing extended care will need to have a crib size sheet and blanket, labeled with the child's name. These will go home each week to be laundered and returned with the child.
- Your child's name should be on all items sent to the Center. This includes hats, coats, boots, blankets, etc.

## THINGS TO REMEMBER

- Children should not bring treats, gum, candy or money to the Center. Please check with the Director if you wish to bring treats for a special occasion.
- Please do not bring toys from home. The Center has an adequate supply of toys. However, if your child wishes to bring a special toy on "sharing day", please check with the Director. WE cannot be responsible for lost or broken toys.
- Be sure to check your child's cubby for messages, possessions, and "valuable" artwork.
- A nutritious snack consisting of a beverage, fruit, vegetable, crackers, etc. will be served mid-morning and afternoon. Children staying later than 11:15 a.m. will need to bring their own lunches. Please make sure you send a nutritious lunch, making sure to have no more than one small treat. Please do not include candy or soda pop for lunch.
- Scrapes and scratches will be washed and bandaged. An "ouch" report will be sent home. More serious injuries requiring medical attention will be referred to the emergency clinic in Shingletown or local hospital if necessary. Parents will be notified immediately in case of emergency.
- It is necessary to keep the lines of communication open concerning the needs of you and your child. Please inform the Director if there is a serious problem at home such as a change routine, illness, divorce, death, new baby, etc. We want to be of help to the families in the Center. You and your child are important to us.

# SHINGLETOWN EARLY CHILDHOOD LEARNING CENTER
# POLICY AGREEMENT

## TUITION

- Tuition payments are to be made on or before the first day of each month unless you have arranged, in advance, with the Director. Payments are considered late on the 7th of each month and a late fee of $10.00 will be added at that time.
- Please note the monthly fees will remain the same regardless of the length of the month, holidays, vacations or absences. (Please see "Payments and Fees" information in the Handbook).
- There are no credits allowed for missed days during the month.
- Two weeks written notice must be given before a child is dropped from enrollment; if notice is not given, you will be billed for this period.
- Advance notice of at least thirty (30) days will be given if there is a need for a rate change.
- Parents/Guardians have the right to inspect the Center in accordance with Health and Safety Code Section 1596.857.

## ATTENDANCE

- Children must be signed in and out of the Center each day by the parent/guardian.
- There will be no deduction in fees for late arrivals.
- Please call the Center Office at **530-474-4700** if your child is unable to attend.
- If a parent/guardian needs to speak with a teacher for longer than a few minutes, please make an appointment.
- Children will be released only to parents/guardians, or to persons designated by parents/guardians only if the teacher has been notified in writing. Please have designee ready to show a photo ID when picking up your child.
- There is a health check of each child upon arrival. If the child is ill, he/she will not be allowed in school that day.
- No child who has a fever is unable to function, or who has a yellow or green nasal discharge will be allowed to stay at school.
- If a child becomes ill at school, he/she will be isolated from other children and the parent/guardian will be expected to pick up their sick child as soon as possible.
- Children must be up to date on their immunizations as specified by the State of California, prior to enrollment. A photocopy of immunizations and a current TB skin test are required. The child's Physicians Report must be in the office within 30 days after the child enters the Learning Center.

## REASONS FOR REMOVAL

- Nonpayment of the rate for basic services in advance and when due and payable.
- Inability of the school to meet the needs of the child.
- If a child's behaviors disrupts school activity, other children, teachers, or the Learning Center program, or if a child displays overly aggressive behavior such as biting or hurting other children or staff, a parent/teacher. A conference will be held with the child's parent/guardian. If the behavior continues, the child will be dismissed from the program.

We, the undersigned, agree to the conditions of this "Policy Agreement" and have received a copy of the conditions outlined herein.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____