Lakeside Union School District

EXTENDED STUDENT SERVICES

Lakeside Early Advantage Preschool Programs

9745 Marilla Drive
Lakeside, CA 92040

12824 Lakeshore Drive
Lakeside, CA 92040

Robyn Bowman-Preschool Manager (619) 390-2391 Ex. 2900 or rbowman@lsusd.net
Cell: (619) 438-8955 Fax: (619) 390-2392

REGISTRATION CHECK OFF LIST

Date Received:_____ Child's Name:_____

Birth Date:_____ Age as of November 1st:_____

All LEAPP Classes

- o LEAPP Registration Form
- o LUSD Registration Form
- o Emergency Information
- o Parents' Rights
- o Personal Rights
- o Consent for Emergency Medical Treatment
- o Internet and Photo Agreement
- o Admission Agreement
- o Child's Preadmission Health History
- o Physician's Report
- o Payment Authorization Form

Copies of:

- o Birth Certificate
- o Current Immunization Record

LEAPP State Classes

- o Income Calculation Worksheet
- o Self-Declaration of Income
- o Statement of Release
- o Zero-Income (if needed)
- o Residency Verification Checklist
- o Certification of Eligibility
- o Notice of Action
- o Family Needs Form
- o Family Language Instrument

Copies of:

*One-month **current** check stubs
*Two proofs of residency
*Birth Certificates of **ALL** children (under 18 living in the home)
*Current Immunization Record

Lakeside Union School District

LEAPP

Lakeside Early Advantage

Preschool Programs

Student Name:_____ D.O.B:_____ Gender: ☐M ☐F

Preschool Class: ☐Tuition-based Spanish-enriched (3-hour Class) ☐AM (7:45AM-10:45AM) ☐PM (11:45AM-2:45PM)

☐Tuition-based Traditional English (3-hour Class) ☐AM (8:00AM-11:00AM) ☐PM (11:45AM-2:45PM)

☐Tuition-based Spanish-enriched (6-hour Class, 7:45AM-1:45PM)

☐Tuition-based Traditional English (6-hour Class, 8:00AM-2:00PM)

☐State-funded (3-hour Class, 5-days, M-F) ☐AM (7:45AM-10:45AM) ☐PM (11:30AM-2:30PM)

Days of the week (tuition-based only): ☐2 Days-T/TH ☐3 Days-M/W/F ☐5 Days-M-F **Extended Day CARE:** ☐Y ☐N

Parent / Guardian Information: (Responsible party indicates: financial, full account access, & allowed to make updates)

Parent/Guardian:_____ Phone 1:_____ Phone 2:_____

Address:_____

Required-E-mail Address:_____ **Lives With:** ☐Yes ☐No **Financially Responsible:** ☐Yes ☐No

Parent/Guardian:_____ Phone 1:_____ Phone 2:_____

Address:_____

Required-E-mail Address:_____ **Lives With:** ☐Yes ☐No **Financially Responsible:** ☐Yes ☐No

Emergency Contact Other Than Parent / Guardian:

Name:_____ Relation:_____ Phone 1:_____ Phone 2: _____

Name:_____ Relation:_____ Phone 1:_____ Phone 2: _____

Name:_____ Relation:_____ Phone 1:_____ Phone 2: _____

Name:_____ Relation:_____ Phone 1:_____ Phone 2: _____

Name:_____ Relation:_____ Phone 1:_____ Phone 2: _____

Medical Information:

Please indicate any medical conditions that the staff should be aware of and/or that would limit your child's activities (i.e. allergies, asthma, injuries, etc…)_____

If your child needs any medication, please indicate. Before any medication may be administered by staff, a completed physician's form must be on file.

Medication:_____ Approx. time of day:_____

The above information is current and accurate:

_____ _____

Parent Signature Date

Program Use only

Changes:

Class: State-funded: ☐AM ☐PM **Tuition-based:** ☐AM ☐PM ☐Full-Day **Extended Day CARE:** ☐Y ☐N

Days of the week (tuition-based only): ☐2 Days-T/TH ☐3 Days-M/W/F ☐5 Days-M-F Date:_____

Program Notes: (i.e. employee, charges, alternate payment) _____

LAKESIDE UNION SCHOOL DISTRICT REGISTRATION ***SCHOOL NAME:***

FOR OFFICE USE ONLY: TEACHER			***FOR OFFICE USE ONLY:*** PERM ID #	***FOR OFFICE USE ONLY:*** SSID#		***FOR OFFICE USE ONLY:*** DATE ENROLLED:		
STUDENT LAST NAME:			FIRST NAME:		MIDDLE NAME:		GRADE:	
GENDER: *Check-X*	MALE ☐	FEMALE ☐	SOCIAL SECURITY#	LANGUAGE SPOKEN AT HOME		PARENT E-MAIL		
BIRTHDATE: *MO/DAY/YR*			BIRTH CITY	BIRTH STATE		BIRTH COUNTRY		BIRTH VERIFICATION
Is student Hispanic/ Latino*? Check -X*	YES ☐	NO ☐	NICK NAME/ALIAS (AKA)					
STREET ADDRESS:								
CITY		STATE	ZIP					
MAILING ADDRESS-IF DIFFERENT FROM ABOVE								
PRIMARY PHONE NUMBER:								
SECONDARY PHONE NUMBER:								
HAS YOUR CHILD EVER BEEN ENROLLED IN THIS DISTRICT? **Y** ☐ **N** ☐								

Secondary Race ***CHECK/CIRCLE ONE***

20-AMERICAN INDIAN OR ALASKA NATIVE ☐	46 ASIAN-KOREAN ☐	47 ASIAN-LAOTIAN ☐	40 ASIAN-OTHER ☐	63 PACIFIC ISLANDER-SAMOAN ☐
44 FILIPINO ☐	43 ASIAN CHINESE ☐	48 ASIAN-VIETNAMESE ☐	42 ASIAN-CAMBODIAN ☐	62 PACIFIC ISLANDER-HAWAIIAN ☐
30 BLACK ☐	45 ASIAN-JAPANESE ☐	41 ASIAN-INDIAN ☐	49 ASIAN-HMONG ☐	64 PACIFIC ISLANDER-TAHITIAN ☐
10 WHITE ☐	61 PACIFIC ISLANDER-GUAMANIAN ☐			60 PACIFIC ISLANDER-OTHER ☐

Student Residential Status (Check /Circle One): Parent/Legal Guardian ☐ Foster Family Home ☐ Foster Group Home ☐

Homelessness-(living with someone due to financial hardship) ☐ Homelessness-hotel/motel ☐ Homelessness- sheltered ☐

Homelessness-unsheltered ☐ Residential Facility ☐ Hospital (not state hospital) ☐ Other ☐

SCHOOL STUDENT LAST ATTENDED:

ADDRESS:		GRADE LEVEL
CITY	STATE/ZIP	PHONE NUMBER

WAS STUDENT IN A SPECIAL EDUCATION PROGRAM IN PREVIOUS SCHOOL? **Y** ☐ **N** ☐		DOES STUDENT HAVE AN ACTIVE IEP? Y ☐ N ☐		HEALTH ISSUES
FATHER'S LAST NAME:	FIRST NAME:	EMPLOYER:	WORK PHONE:	STUDENT LIVES WITH THIS PARENT YES ☐ NO ☐ PART–TIME ☐
MOTHER'S LAST NAME:	FIRST NAME:	EMPLOYER:		STUDENT LIVES WITH THIS PARENT YES ☐ NO ☐ PART-TIME ☐

PARENT WITH THE HIGHEST LEVEL OF EDUCATION: *REQUIRED IN ACCORDANCE WITH CALIFORNIA STATE LAW* ***PLACE AN X IN THE HIGHEST LEVEL COMPLETED***	***DID NOT COMPLETE HIGH SCHOOL*** ☐	***HIGH SCHOOL GRADUATE*** ☐	***SOME COLLEGE*** ☐	***COLLEGE GRADUATE*** ☐	***POST GRADUATE*** ☐

LIST CHILDREN IN FAMILY UNDER AGE 18	NAME	AGE	NAME	AGE	NAME	AGE	
EMERGENCY CONTACT:	NAME		HOME PHONE		CELL PHONE		
PARENT/GUARDIAN SIGNATURE					TODAY'S DATE		

PLEASE FILL OUT BOTH SIDES COMPLETELY – PRINT CLEARLY
LUSD – EMERGENCY INFORMATION

TEACHER______________________________ GRADE______

This address will be used to verify the residency of the pupil per the requirements of state law. Your signature indicates you are providing the information under penalty of perjury.

Pupil's Name (Last name, First) | Birthdate | Sex | #1 Phone Contact | #2 Phone Contact

Student Address | Apt# | City | Zip

FATHER (GUARDIAN) ☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Foster ☐ Other ☐ Male ☐ Female Pupil resides with ☐ Yes ☐ NO

Last Name / First Name / Employer

Address if Different of Student / City / State / ZIP

Home Phone / Cell Phone / Work Phone

Email

Are you active military? Y N Are you employed on government property? Y N

MOTHER (GUARDIAN) ☐ Parent ☐ Step-Parent ☐ Legal Guardian ☐ Foster ☐ Other ☐ Male ☐ Female Pupil resides with ☐ Yes ☐ NO

Last Name / First Name / Employer

Address if Different of Student / City / State / ZIP

Home Phone / Cell Phone / Work Phone

Email

Are you active military? Y N Are you employed on government property? Y N

List the names, addresses and phone numbers of 3 responsible local area residents who know your child and who you authorize to pick up your child in emergencies or illnesses. Your child will be released only to those persons listed below.

NAME	RELATIONSHIP	ADDRESS (including city)	Best Phone Contact #
1.			
2.			
3.			

Physician ______________________ Insurance ______________________ Phone #______________

Date ______________ Signature ______________________________

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: Mission Valley Regional Office

   Licensing Office Address: 7575 Metropolitan Drive Suite 110 San Diego, CA 92108

   Licensing Office Telephone #: (619) 767-2200

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.

Lakeside Early Advantage Preschool Programs

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

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

Mission Valley Regional Office

ADDRESS

7575 Metropolitan Drive Suite 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Diego CA	92108	619-767-2200

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)
Lakeside Early Advantage Preschool	

(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

Lakeside Early Advantage Preschool-LEAPP 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
( )	( )

LAKESIDE UNION SCHOOL DISTRICT INTERNET/ACCEPTABLE USE AGREEMENT / CONSENT & WAIVER
THE FOLLOWING FORM MUST BE READ AND SIGNED BY THE STUDENT AND THEIR PARENT/LEGAL GUARDIAN

By signing the Consent & Waiver form, we, the undersigned student and parent(s) agree to abide by the following restrictions.

Further, my parent(s)/guardian(s) and I have been advised that the district does not have control of the information on the internet, although it attempts to provide prudent and available barriers. Other sites accessible via the internet may contain material that is illegal, defamatory, inaccurate or potentially offensive to some people. While the Lakeside Union School district's intent is to make internet access available to further its educational goals and objectives, users will have the ability to access other materials as well.

The district believes that the benefits to educators and students from access to the internet, in the form of information resources and opportunities for collaboration, far exceed any disadvantages of access. But ultimately, the parent(s)/guardian(s), and teachers of students are responsible for setting and conveying the standards that their students should follow.

The student and his/her parent(s)/guardian(s) must understand that student access to the Lakeside Union School District network is being developed to support the district's educational responsibilities and mission under the supervision of teachers. In addition, the Lakeside Union School District makes no warranties with respect to the Lakeside Union School district Network service, and it specifically assumes no responsibility for:

1. The content of any advice or information received from a source outside the district, or any costs or charges incurred as a result of seeing or accepting such advice.
2. Any costs, liability or damages caused by the way the student chooses to use his/her district network access.
3. Any consequence of service interruptions or changes, even if those disruptions arise from circumstances under the control of the district.

By signing this form, we understand and agree to the following terms:

The district's system shall be used only for purposes related to education. Commercial, political and/or personal use unrelated to an educational purpose is strictly prohibited.

The district reserves the right to monitor any on-line communications for improper use. Electronic communications and downloaded materials, included files deleted from a user's account, may be monitored or read by district officials.

Students are prohibited from accessing, posting, submitting, publishing or displaying harmful matter or material that is threatening, obscene, disruptive, or sexually explicit, or that can be construed as harassment or disparagement of others based on race, national origin, sex, sexual orientation, age, disability, religion, or political beliefs.

Students shall not use the system to encourage the use of drugs, alcohol, or tobacco, nor shall they promote unethical practices or any activity prohibited by law or district policy.

Copyrighted material may not be placed on the system without the author's permission. Users may download copyrighted material for their use only.

Vandalism will result in the cancellation of user privileges. Vandalism includes the intentional uploading, downloading or creating computer viruses and/or any malicious attempt to harm or destroy district equipment or materials or data of any other user.

Students shall report any security problem or misuse of services to the teacher or principal

The principal or designee shall make all decisions regarding whether or not a user has violated these regulations and may deny, revoke, or suspend a user's access at any time. The decision of the principal or designee shall be final.

Photographs and/or videotapes of students are taken periodically in the classroom or at school functions to be used in class bulletins, art projects, school website, promotional materials, video of Outdoor Ed. Program, etc.

I give my permission to photograph my student for the above purposes.
____ Yes
____ No

I give my permission for my student to use the Internet for Educational purpose.
____ Yes
____ No

The Lakeside Union School District maintains a district website as well as individual school site web pages. The website is updated regularly and often will include pictures of students, staff, parents, student work and school activities. This consent form grants the Lakeside Union School District permission to post pictures of my son/daughter and/or samples of his/her work on the district or school website, promotional materials, and other school related videos and the use of the student's first name (only). I further release the Lakeside Union School district and its employees, officials and agents from any liability of any claims, including without limitation, claims for libel, defamation, invasion of privacy and right of publicity, and infringement of proprietary rights, arising out of or relating to the exercise of rights granted under this CONSENT AND RELEASE.

Clearly print student's name

_____

Print name of parent / guardian

_____

Signature

_____

Date _____ School _____

Teacher _____Grade_____

Revised March 2008

Lakeside Union School District

LEAPP

Lakeside Early Advantage Preschool Programs

LEAPP Admission Agreement/Parent Handbook

Date: _____

Please initial each of the following statements. This is for both LEAPP state funded and LEAPP tuition based.

☐ I agree to pay the established tuition required for services based on rates posted by the tuition based LEAPP. I understand that I will receive notice of any change in fees thirty (30) days prior to the date when changes are to go into effect.

☐ All information that I have provided in the LEAPP registration packet is true and correct.

☐ I understand Community Care Licensing Division (CCLD) of the Department of Social Services has the authority to interview children and/or staff, and to inspect and audit childcare records without prior consent. The CCLD has the authority to observe the physical condition of the children, classrooms and playground.

☐ I have read the LEAPP Parent Handbook and agree to all policies and procedures. I understand that failure to follow these policies may lead to termination of services.

Child's Name: _____

Parent/Guardian Signature: _____

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE 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 ☐ Asthma ☐ Rheumatic Fever ☐ Hay Fever		☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Mumps		☐ Poliomyelitis ☐ Ten-Day Measles (Rubeola) ☐ Three-Day Measles (Rubella)	

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 / AUTHORIZED REPRESENTATIVE 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/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE 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)

LEAPP . This Child Care Center/School provides a program which extends from 6 : 30
(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)	/ /	/ /	/ /	/ /	/ /
DT/Td (DIPHTHERIA, TETANUS AND AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
(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

Automated Payment Processing
Safe – Convenient – Easy

Child's Name:_____

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) LEAPP to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name | Phone #

Cardholder Address | City | State | Zip

Account Number | Expiration Date | CVV (3 numbers on back of card)

Cardholder Signature | Date

SECTION B (Bank Account)

Your Name | Phone #

Address | City | State | Zip

Bank or Credit Union Name | Bank or Credit Union Address | City | State | Zip

Routing Transit Number (see sample below) | Account Number (see sample below) | ☐ Checking ☐ Savings

Authorized Signature | Date

For Official Use Only

Date Received
Employee Signature

A service of

procare SOFTWARE®