Castle Oaks Children's Center

Infant through Kindergarten Learning Academy

INFANT

Dear parents,

The state of California does not allow us to have children enrolled, whose files are not current.
To complete your child's file, we need the following Completed documents:

SOCIAL SERVICES CHECK LIST

- ❑ IDENTIFICATION AND EMERGENCY INFORMATION (LIC. 700)
- ❑ PRE-ADMISSION HEALTH HISTORY – PARENTS REPORT (LIC. 702)
- ❑ PHYSICIANS REPORT (LIC. 701) TB (OVER 2 YEARS)
- ❑ CONSENT FOR MEDICAL TREATMENT (LIC. 627)
- ❑ IMMUNIZATION RECORD (BLUE CARD) (PM 286)
- ❑ COPY OF YELLOW IMMUNIZATION CARD
- ❑ ENROLLMENT AGREEMENT
- ❑ PARENTS RIGHTS (LIC 995)
- ❑ INFANT NEEDS & SERVICE PLAN
- ❑ INFANT SLEEPING PLAN
- ❑ INFANT FEEDING PLAN
- ❑ INFANT DIAPERING PLAN
- ❑ PERSONAL RIGHTS (LIC 613A)

SCHOOL REQUIRMENT CHECK LIST

- ❑REGISTRATION FORM
- ❑MEDICATION AND ALLERGIES HISTORY
- ❑EMERGENCY INFORMATION CARD
- ❑PARENT HANDBOOK RECEIPT
- ❑HOLIDAY SCHEDULE
- ❑AUTHORIZATION TO DISPLAY PICTURES/VIDEO
- ❑ POTTY TRAINING
- ❑ BITTING INFORMATION
- ❑ MOON BOUNCE PERMISSION SLIP
- ❑ FIELD TRIP PERMISION SLIP
- ❑ INFANT SUPPLY LIST
- ❑ FOOD PROGRAM/DECLINING FORM
- ❑ WAIVER OF LIABILITY RELATING TO COVID-19
- ❑ EMERGENCY EVACUATION FORM
- ❑ LEAD POISONING FACTS

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IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST		MIDDLE	FIRST		SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

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		☐ 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 / 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

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)

Castle Oaks Children's Center . 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., Five days a week.

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

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

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

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

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

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

Castle Oaks Children's Center
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
( )	( )

State of California—Health and Human Services Agency

California Department of Public Health

CALIFORNIA PRE-KINDERGARTEN AND SCHOOL IMMUNIZATION RECORD

Pre-kindergarten facility and school staff must record the required vaccine dose information and status of requirements for each pupil. *See reverse side for guidance.*

PUPIL NAME (LAST, FIRST, MIDDLE)	STATEWIDE STUDENT IDENTIFIER (SSID)	ETHNICITY	RACE
	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other _____
NAME OF PARENT/GUARDIAN (LAST, FIRST)	BIRTHDATE (MONTH/DAY/YEAR) ___ ___ ___ ___ ___ ___ ___ ___	SEX _____	

REQUIRED VACCINE	DATE EACH DOSE WAS GIVEN (MM/DD/YY) 1ST	2ND	3RD	4TH	5TH	Permanent Medical Exemption	Notes for School Requirements
IPV / OPV (Polio)			Age:_____ years			☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTaP / DTP – Age 0-6 years **Tdap / Td** – Age 7+ years (Diphtheria, Tetanus, Pertussis)			Age:_____ years	Age:_____ years		☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7th Grade requirement.
MMR (Measles, Mumps, Rubella)	Age:_____ months					☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
Hib (*Haemophilus influenzae* type b)						☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
Hep B (Hepatitis B)						☐	3 doses meet TK/K-12 requirement.
VAR / VZV (Varicella or Chickenpox)						☐	2 doses meet TK/K-12 requirement.
Tdap – 7th Grade (Tetanus, Diphtheria, Pertussis)	Age:_____ years					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7th-12th grade admission.

STATUS OF REQUIREMENTS	Staff Initials *I reviewed pupil's Immunization record*	Has All Required Vaccine Doses	Requires Follow-up: Temporary Medical Exemption	Requires Follow-up: Missing Doses Not Currently Due—Conditional	Requires Follow-up: Missing Doses Are Overdue—Needs Doses Now	Follow-up Date(s) (See conditional admission schedule or exemption end date)	Other *See codes on reverse side*	Date Requirements Met
Pre-Kindergarten (Child care or preschool)		☐	☐	☐	☐		☐ IEP ☐ PBE (pre-2016)	
TK/K-12		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home ☐ PBE (pre-2016)	
7th Grade (Advancement or admission)		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	

CALIFORNIA SCHOOL IMMUNIZATION RECORD

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

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

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

Name of Parent or Guardian _____

Race/Ethnicity:
☐ White, not Hispanic
☐ Hispanic
☐ Black
☐ Other: _____

Address _____

Telephone _____ (Daytime) (Nighttime)

City _____ **ZIP** _____

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

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

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

CHEST X-RAY (Necessary if skin test positive)

Film date: _____ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

I. DOCUMENTATION

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

Date _____

Staff Signature _____

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

II. STATUS OF REQUIREMENTS

☐ A. All Requirements are met.
Date _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

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

III. 7th GRADE ENTRY

☐ A. All Requirements are met.
Name _____ Date _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.
Name _____ Date _____

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required...

Castle Oaks Children's Center
Infant – Toddler Enrollment Agreement

LIC # 197413799

For Castle Oaks Children's Center to operate in an efficient manner, enabling us to provide the best program possible for our child, all parents must cooperate and adhere to the following policies:

Hours of Operation: Castle Oaks Children Center's full day Infant program operates Monday – Friday 6:30 a.m. to 6:00 p.m. except for selected holidays, which are stated in our school Calendar.

Admission requirements: Children enrolled in the Infant Program must be between the ages of 6 weeks and 24 months old, be in good health and capable of participating in the school's program. Children may progress to the preschool at 24 months if the school and the parent agree the child is ready for that experience.

Fees Due Upon Enrollment:

Registration Fee – An annual registration fee of $100 per child is required for all Infant through pre-school enrollees. (A 50% discount is offered for each additional child enrolled in our program at the same time).

Security Deposit – a security deposit of $165.00 is required for all students at the time of enrollment. This deposit will be credited towards your child's last week of enrollment. This deposit may also be made in the form of four equal payments, with the approval of the director.

Accident Insurance Fee – a onetime fee of $60.00 will be charged from all children enrolled in our program.

Emergency Kit: An emergency kit is required for all children and can be purchased from our school at the nominal fee of $20.00.

Tuition: Tuition is always payable in advance and is due on the first day of your child's attendance. For **Weekly Payees, tuition is due on Monday of each week. Monthly Payees must submit tuition by the 1st of the month.** Please note that there is no credit given for sick days, vacations, holidays, or absences for any reasons. **If you are taking a vacation, please note that you will be responsible for your tuition. You will be required to continue making the tuition payments to insure your child's place in school. ____ Initial**

Late Fees: All tuition not received by their due dates is subject to a late fee of $10.00 per day. _____Initial

Return Check Fee: There is a $25.00 return check fee for checks returned by your bank for any reason. _____Initial

Late Pick-up Fee: Please make sure to notify the school in case you are unable to pick them up before their scheduled departure time so that we can reassure your child. If, however, your child
is picked up after 6:00 p.m. a late fee of **$1.00 per minute** will be assessed and is **payable in cash to the teacher on duty** at the time of pick-up. _____Initial

Pick-up of ill children: You will be called if your child becomes ill at school. If we are unable to reach you, we will attempt to contact everyone on your Emergency Contact list. Sick children must be picked up promptly or **a fee of $5.00 is charged for every 15-minute period after the first 45 minutes of our call.** _____Initial

INFANT-TODDLER (6 weeks to 2 years) TUTION RATES

Full-time Weekly	Part-time Weekly
$398.00	$300.00

Modification Conditions:
The school will provide the parents with a 30-calendar day written notification of any basic tuition rate change. _____Initial

Fundraisers: There are two (2) fundraisers a year and each family is required to participate. _____Initial

Termination: A two-week advanced written notice is required for a child to be withdrawn from the school program. Failure to provide proper notification will result in the forfeiture of the security deposit or up to two weeks prepaid tuition. _____Initial

Holidays: We charge for all holidays. No adjustment of tuition will be made for holidays. Management reserves the right to make any adjustments to the holiday schedule as deemed necessary. A 30-day notice will be provided for all parents regarding any changes to the published holiday calendar. _____Initial

Inappropriate behavior: Inappropriate language, discriminatory and or derogatory comments by a child/parent is not tolerated in the school. Any child/parent found to be engaging in any verbal and or physical confrontation will be subject to immediate disciplinary action not withstanding suspension and or dismissal from the school. **Cell Phones, and iPads, are prohibited in school.** Castle Oaks Children's Center reserves the right to terminate a child without prior notice, due to inappropriate behavior/language by the child/parent or if staff/children at the facility are threatened, put in danger or due to any safety violation by a child/parent. **Castle Oaks Children's Center will not tolerate Bullying.** _____Initial

Safety: The safety of all children is the school's primary concern. Please make sure that you drop off your child to a member of our staff. All children must be sign in and out each day. All drop offs and pick-ups must be done inside the school and not in the parking lot. _____Initial

Inspection Authority: The Department of Social Services has the authority to interview the children and the staff and to enter the facility without prior consent or advanced notification. _____Initial

Financial Information:

By completing this box and signing below you are agreeing to the terms and conditions of this Enrollment Agreement.

This agreement is between _____ and Tampe Management Inc. dba. Castle Oaks Children's Center for the child (ren) _____.

I/We hereby agree to pay Castle Oaks Children's Center the amount of $ _____ Per ☐ Week ☐ Month

Due on ☐ Monday for weekly payees and or ☐ 1st of the month for the monthly payees.

SUBSIDISED PROGRAM PARENTS: (CCRC, DCFS, Crystal Stairs, CalWORKs, Gain)

I have been notified that I will be responsible for payment for services if my eligibility is terminated or under paid by the subsidized program. _____ **Initial**

Primary:

First Name	Last Name	Address	City	Zip	Home Tel	Work Tel
E-Mail:						

Secondary:

First Name	Last Name		Address	City	Zip	Home Tel	Work Tel
E-Mail:							

Closest Relative information:

First Name	Last Name	Address	City	Zip	Home Tel	Work Tel

Arbitration Statement: I/We further agree to arbitrate any disputes or disagreements that may arise from the care of my child(ren) with Castle Oaks Children's Center in accordance with the rules and regulations of the American Arbitration Association except for amounts owed to the facility for tuition or other fees. _____Initial

Discontinuation of Services: Castle Oaks Children's Center reserves the right to terminate services for failure to comply with any of our policies. The undersigned understands that if such a termination were required that the security deposit would be forfeited.

By signing below, you indicate that you have read, understood, and received a copy of this Enrollment Agreement and the Castle Oaks Children's Center program and Parent Handbook and agree to abide by its terms.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Parent/Guardian'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: California Department of Social Services

   Licensing Office Address: 300 N. Continental Blvd. #209A, El Segundo, CA 90245

   Licensing Office Telephone #: 424-301-3077

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.

Castle Oaks Children's Center
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

Castle Oaks Children's Center

Infant through Kindergarten Learning Academy

Infant Needs and Service Plan

In order to make your child's time at the school enjoyable, please take a few minutes to fill out this need and services plan for _____

i. Does your child use a bottle? Yes ☐ No ☐
At What Time? _____

ii. At what time does your child eat Breakfast? _____ Lunch? _____
Dinner? _____ Snack? _____

iii. Does your child have any Allergies? Yes ☐ No ☐
If Yes What? _____

iv. Does your child use diapers? Yes ☐ No ☐
Is your child potty trained? Yes ☐ No ☐
What is your child's toileting schedule? _____
When are their usual bowel movements? _____
What word (s) do they use for Bowel movements? _____
What words do they use for urination? _____

v. Does your child take a nap? Yes ☐ No ☐
How do you usually get them to sleep? _____
Do they have a "lovey" that they sleep with? _____
What time do they usually nap? _____

vi. Does your child require any special attention? Yes ☐ No ☐
If so what? _____

vii. Has your child ever been left with anyone other than family? Yes ☐ No ☐

viii. What usually happens when you separate from your child? (do they cry, how long, etc.) _____
_____
_____

ix. Any other special things you may want us to know to make this new adventure eventless? _____
_____
_____

6733, Corbin Avenue, Canoga Park CA 91306
Phone :(818) 881-7333 *Fax: (818) 757-0140

Sleeping Instructions

Child's Name: _____ Date: _____

This is when I usually sleep:

Time	Where	How Long

I am comfortable sleeping in my:

_____ Crib _____ Bed _____Infant-seat _____Swing

_____ Stroller _____Car Seat _____ Snugly _____ Other

I like to sleep:

_____ On my Back _____ On my side _____ on my stomach

_____ With my bottle _____ with my pacifier _____ Other

This is how I go to sleep at home:

_____

_____

_____

_____

_____

_____

SPECIAL INSTRUCTIONS AND NOTES:

_____

_____

_____

_____

_____

FEEDING INSTRUCTIONS

CHILD:_____ DATE: _____

This is when I usually eat:

TIME	KINDS OF FOOD	AMOUNTS

This is how I usually eat:

_____ Bottle _____ Infant-feeder ____ I feed myself ____ Cup _____Spoon

_____ I am fed _____ Baby seat _____ High chair _____ I am held

This week I am eating:

_____ Strained foods _____ Junior foods _____ soft table foods

_____ Formula _____ Milk _____Diluted Juices ____ Fruits ____ Meats

_____ Vegetables ____ Cereal _____ Breads _____ Biscuits/ Crackers

This is how to fix my food:

_____

_____

_____

_____

_____

_____

Diet restrictions and allergies:

_____

_____

_____

_____

_____

_____

Diapering Instructions

Child's Name: _____ Date: _____

My parents use these when they change my diaper (Write in the name used for each):

Wipes _____ Powder _____

Lotion _____ Ointment _____

When I have a rash, my parents usually do this:

_____

_____

_____

_____

This is how I feel about having my diaper changed:

_____

_____

_____

_____

SPECIAL INSTRUCTIONS AND NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

California Department of Social Services

ADDRESS

300 N. Continental Blvd. #209A

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
El Segundo	90245	424-301-3077

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)
Castle Oaks Children's Center	6739 Corbin Ave., Canoga Park CA 91306

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)