E-SOL

PARTICIPANT CHECKLIST

Cover sheet for consumer packet

Child after school

Name_____
Program Location_____
Emergency Phone No's_____
_____
_____

Hours approved Reg._____
Min_____
Ext_____

Caseworker's name_____
Caseworker's tel #_____

The specific items & forms listed below will be checked in the space provided to assure all documents required by participant are completed. (Documents with data on backside should be photocopied either as two separate pages or as two-sided heat to foot copies.)

__Tab 1. Approval form (NLACRC)
__Tab 2. IEP Goals
__Tab 3. Admission & Agreement Policies Acknowledgement form
__Tab 4. Late pick-up Policy
__Tab 5. Identification and Emergency Information & Intake Emergency Card
__Tab 6. Medical Information & Educational Information
__Tab 7. Photographic Release form
__Tab 8. Authorization to Administer Medication form (if applicable)
__Tab 9. Seizure Procedures form (if applicable)
__Tab 10. Request for Release of Information
__Tab 11. Aquatic Program Release form
__Tab 12. Consent for Emergency Treatment Form
__Tab 13. Physician's Report (signed by physician)
__Tab 14. Parent's Report
__Tab 15. Parent's Rights
__Tab 16. Personal Rights

E-SOL

Child After School Program

ADMISSION POLICY

E-SOL (ENRICHMENT AND SOCIAL OPPORTUNITIES FOR LIFE SKILLS) is a non-profit organization dedicated to providing quality service and care to meet the challenging needs of each consumer. Our goal is to promote and encourage social skills and interaction through group participation.

With integrity and dedication our commitment is to:

- Foster the development of a health self-esteem
- To strengthen individual, as well as group, participation skills
- To provide age appropriate activities
- Encourage the development of friendship, camaraderie and fun
- To provide challenges that will enrich the lives of our consumers
- Support and continue to build on goals and objectives pre-established by consumer, family, school, Regional Centers and other accredited agencies
- To develop improved communication skills
- To provide a safe environment that caters to the consumers' special needs, including but not limited to, developmental, Severe Emotional Disturbances and Autism to multiple special needs that include any combination such as hearing impairments, visual impairments, orthopedic handicaps, emotional disturbances and/or other health impairments

Fees and Payments

Rates and refund policies

Fees are based upon a weekly reservation of enrollment at a rate of $7.79 per hour. Scholarships may be available. Please request further information and an application from the Center Director. **E-SOL** is a vendor with the Regional Center (818) 778-1900.
No refunds will be issued after service has been provided.

Registration Requirements

E-SOL will have all admission policies in writing and available to the public. The policies shall coincide with the limitations stated on the license, and shall include, but not be limited to, the following:

Persons accepted for care, including age range and compatibility determination process, when necessary.

E-SOL will be providing services for consumers with special needs and will strive to meet the individual needs of each consumer. Consumers who are 7-18 years old and enrolled in a public education program may be eligible for this program. **E-SOL** after school program is specially designed to meet the needs of consumers who have physical and/or developmental disabilities. Schools, case managers, physicians, or friends may make referrals for this program. Each referral will be evaluated on an individual basis to determine whether the applicant is appropriate for our services.
Consumers will be evaluated regardless of race, creed, color, national origin or sex.
Consumers must **NOT** exhibit excessive assaultive or self-abusive behaviors and must **NOT** require medical staffing. **E-SOL** reserves the right to refuse service or placement to applicants considered inappropriate

Application/ Intake Forms

Consumers registering in the **E-SOL** after school program must complete the following application forms as mandated by both state licensing and/or **E-SOL** policy:

1. Admission Policy Acknowledgement
2. Late Pick-up policy
3. Medical Information
4. Education Information
5. Photographic Release
6. Authorization to Administer Medication
7. Seizure Procedures
8. Request for Release of Information
9. Aquatic Program
10. Consent for Emergency Medical Treatment
11. Identification and Emergency Information
12. Physician's Report
13. Parent's Report
14. Parent's Rights
15. Personal Rights

Licensing Authority

E-SOL is licensed to provide after school programs through the State Community Care Licensing division according to and in compliance with Section 101195 of Title 22.

Program Information

1. **Operation Hours**

   Regular school session--3 p.m.-6:30 p.m. Monday - Friday (mid-afternoon snack will be provided).

   Minimum day schedule--12:30 p.m.-6:30 p.m. Monday - Friday (mid-afternoon snack will be provided).

   Summer school schedule--12:30 p.m.-6:30 p.m. Monday - Friday (mid-afternoon snack will be provided).

   Extended day schedule (no school)--8:00 a.m.-6:30 p.m. Monday - Friday based on a minimum number of 6 consumers requiring services (mid-morning and mid-afternoon snack will be provided).

   Lunches will not be provided, parents or guardians must make arrangements for lunches.

2. **Holidays**

   E-SOL will be closed on the following holidays:

New Year's Day	Martin Luther King Jr.'s Birthday
President's Day	Memorial Day
Fourth of July	Labor Day
Veteran's Day	Thanksgiving Day
Friday after Thanksgiving	Christmas Day

3. **Attendance**

   Regular attendance is required. Please call and notify **E-SOL** if consumer is going to be absent or late for any reason.

4. **Participation**

   All consumers will be expected to participate in all activities to the best of their abilities.

5. **Transportation**

   E-SOL is not responsible and does not provide transportation to or from the facility. Transportation to the facility may be arranged through the consumer's school, Regional Center, or other transportation services. Additionally, parents\guardians are solely responsible for consumers' pick-up.

6. **Parent Conferences\Observations**

   Upon request by parent\guardian, and in collaboration with a director, a conference will be arranged to review and\or update goals and objectives of the consumer.

7. **Health and Safety**
A pre-admission Health history form is required for every participant. Please inform **E-SOL** of any changes regarding physical, emotional or medical issues.

8. **Illness\Injury**
In the best interest of the safety of other participants as well as staff members, we request that sick or injured participants remain at home until fully recovered or a conference can be arranged to assess the best action for the participant.

9. **Medication**
E-SOL will administer medication **ONLY** with written permission (consent form included in admission packet) from parent\guardian, care provider and the physician (prescription label on medication bottle is acceptable).

10. **Sign in\Sign out policy**
In compliance with State Licensing requirements, each participant must be properly signed in and out with a full signature on the **E-SOL** roster.

11. **Personal Belongings**
E-SOL will not be responsible for lost, stolen or damaged personal belongings. As we understand accidents do occur, please do not send valuable or new items whenever possible. To avoid confusion parents\guardians should clearly mark all personal items.

12. **Staff Training days**
To ensure the highest quality and service, **E-SOL** may be closed for up to 5 days per calendar year for necessary staff training sessions. Parents will be given ample (written) notification.

Scheduled Activities

- Arts and Crafts--creating different art projects such as collages, posters, jewelry art and tie dye art by utilizing various modalities and materials.
- Tutoring to reinforce educational needs
- Computer Integration - providing assistance for Internet and other age appropriate enriching computer programs
- Sports Activities - spectator and/or participant in aerobics, basketball, handball, soccer, etc.
- Recreational Activities - music, dance, various board games, puzzles and computer games.
- Cooking - assembling and serving simple meals and snacks
- Swimming
- Bowling

Sample Daily Schedule (activities will vary from day to day)

3:00 - 3:45	Tutoring
3:45 - 4:30	Cooking and Snack Time
4:30 - 5:00	Arts and Crafts
5:00 - 5:30	Sports Activities
5:30 - 6:00	Recreational Activities
6:00 - 6:30	Prepare to go Home

E-SOL Staff

Because we are an enrichment program and not just a Day Care, **E-Sol** staff is selected for their qualifications that exemplify the high standards and principles of our organization. All staff must meet or exceed the State of California Department of Social Services Community Care Licensing criteria for employment. (Title 22, section 101216, 101316.2 and 101316.3).

To ensure the best quality service for participants the Directors of **E-SOL** have over thirty years of combined experience of working with children with special needs.
Our staff currently consists of a Credentialed LAUSD teacher of students with disabilities, twelve (12) LAUSD certified Special Education Assistants, and a mother of a son with multiple disabilities including visual impairment. Additionally, we have a certified dance instructor come in on a regular basis to teach dance and aerobics. **E-SOL** will continue to expand community involvement through assemblies, field trips and incentive programs.
All staff members are trained in adult and child First Aid and CPR.
The staff to participant ratio will be approximately 1:5.

Discipline Policies

E-SOL will strive to meet the needs of all participants in our programs without ignoring the demands of any one individual. It is necessary when organizing a group to set limits and guidelines which each member of the group and program is expected to follow. When those limits are broken, it is essential to provide some form of understanding. Ensuring safety while providing a high quality and effective program will be the main priority of **E-SOL** and its staff.

Target *inappropriate* behaviors may include:

- Excessive defiance in complying with staff rules and regulations
- Constant self abuse
- Disruptive behaviors towards staff or other participants
- Violent tantrums; tantrums that cannot be controlled

AT NO TIME will **E-SOL** staff use corporal punishment to resolve conflicts.
The following process will be used to resolve conflicts as they happen.

Types of discipline that will be used

1) Verbal Communication--Every effort will be made to help the participant understand the inappropriateness of his/her actions or behaviors. The participant will then be given a choice between a few acceptable actions or behaviors. When the conflict is participant -to-

participant, efforts will be made to have them verbally work out their differences with the staff providing facilitator support.

2) Removal from the specific activity--If verbal communication is not successful, removing the participant from the activity for an appropriate amount of time may be necessary. The denied activity shall be directly related to the inappropriate behavior or action and the removal time shall **NOT** be excessive.

3) Participant/Director conference--If removal from the activity is not successful, the Program Supervisor will be consulted to meet with the program staff and the participant to develop an alternate behavior plan.

4) Participant/Parent/Director conference--If parent involvement becomes necessary, specific changes in behavior will be requested and specific consequences for non-success will be defined. As well as specific rewards for successful and positive changes in behavior will be emphasized and promoted. Whenever possible and appropriate, the participant will participate in these meetings.

Types of discipline not permitted

At **NO** time will **E-SOL** staff use corporal punishment/violation of personal rights to resolve conflicts.

Grounds for dismissal/eviction/relocation/removal from placement

When all measures to positively change inappropriate behaviors have been exhausted and been unsuccessful, or if such behaviors are deemed to represent a danger to others or to the participant, then the participant may have to be removed from the program---either on a temporary or permanent basis. The Program Supervisor and the Center Director must approve re-entry into the program.

E-SOL ACKNOWLEDGEMENT FORM

I have read, understand and agree with all the rules, policies and procedures as stated in the previous pages.

_____

Signature of Parent/Guardian

Date_____

E-SOL

Late pick-up Policy

Participant_____

It is imperative that parents arrange for their children's transportation home from all E-SOL centers. Parents are also responsible for developing a consistent alternative transportation plan to be used, in the event of an emergency, when they are unable to provide transportation.

E-SOL CLOSES PROMPTLY AT 6:30 p.m.

Late pick up charges are $1.00 per minute starting at 6:31 p.m. This covers a six-month period starting with first late pick-up. The payment must be received by the following day.

1st occurrence- late fees apply. _____

2nd occurrence- late fees apply, and a warning regarding penalty charges._____

3rd occurrence- late fees apply, and a penalty charge of $25.00._____

4th occurrence- late fees apply, and a penalty charge of $50.00._____

5th occurrence- late fees apply, and a penalty charge of $100.00. Parents must also attend a mandatory conference with the Center Director._____

Excessive late pick-ups (more than five occurrences within a six-month period) may result in discharge from E-SOL programs.

Signature of Parent/Guardian_____

Date_____

E-SOL

MEDICAL INFORMATION

Medications_____
_____

Does participant have Allergies: yes___ no ___ If "yes", please specify: _____
_____

Does participant have seizures or blackouts: yes ___ no ___
If "yes", please tell us what type and under what circumstances they occur:_____
_____
_____

Other Medical Conditions _____

Special Precautions Required _____

Does participant have behavior problems? yes __ no ___
If "yes", please describe _____
_____
_____

Does participant use assistive devices? (Glasses, hearing aids, helmet, braces, crutches, cane, walker, wheelchair [with belt], or?) yes ___ no ___
if "yes", please describe _____

Please indicate any restrictions for:
Walking _____
Standing _____
Sitting _____
Lifting _____
Climbing _____

Is participant self-sufficient in daily living skills, i.e. dressing, eating, toileting? yes ___ no ___
If "no", please specify assistance that is required _____
_____
_____

EDUCATIONAL INFORMATION

(Most recent school attended or currently attending)

School Name_____

Address_____

Name of teacher_____

Referring person/ Agency

Name of Agency_____

Phone_____

Caseworker_____

Phone_____

How will applicant be transported to and from program? _____

_____

_____

Signature Relationship

_____

Date

_____

TO BE COMPLETED BY FACILITY DIRECTOR ONLY!!

Intake date_____Entry date_____Discharge date_____

E-SOL

PHOTOGRAPHIC RELEASE FORM

We do hear-by give our consent to E-SOL to photograph, and without limitation, to use such pictures in connection with any of the work of the organization, and/or purposes of publication in printing matters. Such pictures will always appear in good taste and will not be used to exploit.

_____

PRINT PARTICIPANT NAME

_____

SIGNATURE DATE

_____

PRINT PARENT/GUARDIAN NAME

_____

SIGNATURE DATE

If above named participant is over 18 and unconserved, he or she must sign for themselves.

E-SOL

Authorization to Administer Medication

Participants name_____

Program_____

Medication_____

Generic Name (if applicable)_____

Dosage_____

Times to be administered_____

Doctors name (printed)_____

Doctors' signature_____

Date_____

E-SOL

SEIZURE PROCEDURES

1. Current medical information on a participant's seizure condition must be provided by a Physician. This medical information must be updated at least annually.

2. If a participant has any type of seizure, parents will receive a rpot of the incident.

3. If a participant has a partial seizure that lasts more than 15 minutes, the parents, or the emergency contact, will be called in order to remove the participant from the program so medical attention can be obtained. In the event neither parent or the emergency contact can be reached, staff will attempt (as situation demands) to take consumer to the ER, or 911 will be called.

4. The staff will follow Emergency First Aid and Care Procedures of the Red Cross.

5. If a participant has repeated or frequent seizures, parents may be asked to obtain medical attention in order for the participant to continue in the program.

I agree with the above procedures

_____

Signature of Parent/Guardian Date

TO: _____ RE: _____

_____

_____

E-SOL
REQUEST FOR RELEASE OF INFORMATION

I, the undersigned, hereby give my consent for the release of information from your records to E-SOL. Please direct all information to the address below.

E-SOL
7711 Jellico Ave
Northridge, CA 91325
818-881-4427

The specific information to be released is:

_____
Participant Signature (if applicable)

_____
Parent or Legal Guardian's Signature

_____
Relationship to Participant Date

E-SOL

AQUATIC PROGRAM RELEASE

Name_____Birth Date_____

Address_____Phone_____

Medications_____

Can participant participate in water activities in a heated pool (85-90 degrees) with a lifeguard in the water and poolside (non-swimmers supported by an adult in the water)?

No _____ Yes_____

Can participant participate in the following pool activities:

pool	no ____	yes ____
Wading pool	no ____	yes ____
Jacuzzi	no ____	yes ____

Has participant ever been in a large pool? no ____ yes ____

Is participant afraid of the water? no ____ yes ____

Will participant put his/her face in the water? no ____ yes ____

Has participant ever experienced seizures or other difficulties during swimming?

No ____ Yes ____

If yes, please describe _____

_____

_____

Has participant been given organized swim lessons? No _____ Yes _____

If yes: 1) Where were the lessons given? _____

2) What was the highest level achieved? _____

Does participant require any special equipment (i.e., ear plugs, nose plugs, swim cap, water shoes, etc.?): No _____Yes _____

If yes, please list items _____

Does participant require assistance dressing? No ____ Yes ____

If yes, please explain_____

_____

_____

_____

Signature Date

STATE OF CALIFORNIA- HEALTH AND HUMAN SERIVCEDEPARTMENT OF SOCIAL SERVICES

CALIFORNIA DEPARTMANT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARTICIPANT (OR CONSERVATOR IF NECESSARY), I HEREBY GIVE MY CONSENT TO

_____TO PROVIDE ALL EMERGENCY OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _____

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF PERSON NAMED ABOVE.

PARTICIPANT HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____

DATE SIGNATURE OF PARTICIPANT OR CONSERVATOR

HOME ADDRESS

HOME PHONE WORK PHONE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1. NAME OF CLIENT OR CHILD		SOCIAL SECURITY NUMBER (OPTIONAL)	DATE OF BIRTH	AGE	SEX
2. RESPONSIBLE PERSON OR PLACEMENT AGENCY		ADDRESS		TELEPHONE ( )	
3. NAME OF NEAREST RELATIVE (OPTIONAL)	RELATIONSHIP	ADDRESS		TELEPHONE ( )	
4. DATE ADMITTED TO FACILITY	ADDRESS PRIOR TO ADMISSION				
5. DATE LEFT	FORWARDING ADDRESS				
6. REASONS FOR LEAVING FACILITY					

7. PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

8. OTHER PERSONS TO BE NOTIFIED IN EMERGENCY

NAME	ADDRESS	TELEPHONE
a. PHYSICIAN		( )
b. MENTAL HEALTH PROVIDER, IF ANY		( )
c. DENTIST		( )
d. RELATIVE(S)		( )
e. FRIEND(S)		( )

9. EMERGENCY HOSPITALIZATION PLAN

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY	ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY
MEDICAL PLAN	MEDICAL PLAN IDENTIFICATION NUMBER
NAME OF DENTAL PLAN (IF ANY)	DENTAL PLAN NUMBER (IF ANY)

10. OTHER REQUIRED INFORMATION

a. AMBULATORY STATUS

b. RELIGIOUS PREFERENCE	NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY	TELEPHONE
		( )

11. COMMENTS

SIGNATURE OF RESIDENT	SIGNATURE OF PERSON COMPLETING FORM	TITLE	DATE

B. RESIDENTIAL FACILITIES FOR CHILDREN

(Additional information is required by regulation for residential facilities for children.)

1. NAME OF CHILD

2. NAME AND ADDRESS OF PERSON TO CONTACT, IF AUTHORIZED REPRESENTATIVE IS NOT AVAILABLE	SPECIFY RELATIONSHIP	TELEPHONE NUMBER
		( )
3. NAME AND ADDRESS OF PARENT(S)/PARENT'S DOMESTIC PARTNER, IF KNOWN		TELEPHONE NUMBER
		( )

4. CHILD'S COURT STATUS *(ATTACH CUSTODY ORDERS AND AGREEMENTS WITH PARENT(S), OR PERSON(S) HAVING LEGAL CUSTODY.* **NOTE:** *OPTIONAL FOR SMALL FAMILY AND FOSTER FAMILY HOMES)*

5. **PERSON(S) WITH WHOM CHILD HAS BEEN LIVING (IF KNOWN)**

NAME AND RELATIONSHIP	ADDRESS	TELEPHONE
		( )
		( )
		( )

6. **VISITATION RESTRICTIONS (BY COURT ORDER OR AUTHORIZED REPRESENTATIVE)**

PERSON(S) NOT AUTHORIZED TO VISIT CHILD		PERSON(S) NOT AUTHORIZED TO VISIT CHILD	
NAME	RELATIONSHIP	NAME	RELATIONSHIP

7. **FAMILY RESIDENCE VISITATION RESTRICTIONS**

SPECIFY, IF ANY

8. **ALL PERSONS AUTHORIZED TO REMOVE CHILD FROM HOME**

NAME	RELATIONSHIP	SPECIFY CONDITIONS

9. **TELEPHONE ACCESS**

MAKE AND RECEIVE CONFIDENTIAL CALLS	IF NO, SPECIFY RESTRICTIONS
☐ YES ☐ NO (BY COURT ORDER)	

10. COMMENTS

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

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.

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing LA Northwest Regional Office

   Licensing Office Address: 6167 Bristol Pkway, Suite 400, MS 29-13, Culver City, CA, 90230

   Licensing Office Telephone #: 310-337-4333

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.

E-SOL
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

IMPORTANT INFORMATION

CAREGIVER BACKGROUND CHECK INFORMATION

The law requires that the Community Care Licensing Division check the criminal background of all adults who apply for a license to operate a community care facility. We also check the criminal background of all adults who want to work, reside in or have contact with clients being cared for in a community care facility.

What is a background check?

As part of the background check process you must be fingerprinted and tell whether you have ever been convicted of a crime other than a minor traffic violation. The Department of Justice and the FBI will check your fingerprints against their criminal record information. If you will have contact with children, your name will be checked against the Child Abuse Central Index registry. This is a listing of people who have been reported for suspected child abuse. If you have not been convicted of a crime and have no child abuse history, you will be given a "clearance."

What if I have a criminal conviction?

If you were ever convicted of a crime, other than a minor traffic violation, even if it happened a long time ago, you cannot own, live or work (including some volunteers) in a facility unless we give you an "exemption." If the Department of Justice notifies us that you were convicted of a crime, we will notify the facility operator that an exemption is needed. If you were convicted of a serious crime or if you are on supervised probation after being convicted of a crime, you probably won't be given an exemption.

You do not qualify for a criminal record exemption if you have ever been convicted of a serious crime such as robbery, sexual battery, child abuse, elder or dependent adult abuse, rape, first degree burglary, arson, or kidnapping. These kinds of crimes are **nonexemptible and if you were convicted of one of them, by law you will never be allowed in a facility.**

How do I get a criminal record exemption?

As part of the request for an exemption, the facility operator or you must send us convincing proof that you are of good character in spite of your conviction. We will review any information you submit as well as the number and type of crimes committed, how long ago the crime(s) happened, what kind of work you will be doing and whether you will be working with children, adults, or the elderly. *(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)* If we find that you were not truthful in the information you submitted for your exemption, we will deny your exemption request. In most cases, if you are currently on supervised probation or on parole you will **not** be granted an exemption. If your exemption is denied, and you are married to or living with someone who is applying for a license and care will be provided in your home, his or her application will be denied because everyone who lives in the home must have a clearance or exemption. If a criminal record exemption is granted to you and you later move, or want to work in a different facility, your exemption will be re-evaluated based on your new role and our current laws, regulations, and policies. If you are arrested or convicted after an exemption is granted to you, your exemption may be cancelled. If you are married to or living with someone who is licensed, and care is provided in your home, the facility license may be suspended or revoked.

You are strongly encouraged to read the licensing criminal record exemption regulations to find out the amount of time that must pass following your conviction, before you can qualify for an exemption. Some convictions require longer periods of time following conviction than others. The regulations and other information can be found on our web site at www.ccld.ca.gov.

How long does the criminal record exemption process take to complete?

If you do not have a criminal record, a clearance is normally available in a few days. If an exemption is needed, it may take three months or longer to complete the process.

DISCLOSURE OF CRIMINAL RECORD EXEMPTION INFORMATION UNDER THE CALIFORNIA PUBLIC RECORDS ACT

If you are granted a criminal record exemption, your name will be given out to the public, upon request. If you own a facility and you have staff, residents or volunteers who have a criminal record exemption, the name of your facility will be given out to the public, upon request.

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

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

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)