

ST. MARY SCHOOL

CHRIST CENTERED EDUCATION



Preschool

Application of Admission

17431 Roscoe Blvd. Northridge, CA 91325

Telephone (818) 345 - 3500 **Fax** (818) 345 - 3593

Website: www.thestmaryschool.com **Email:** office@thestmaryschool.com

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ENROLLMENT CHECKLIST

The ability to enroll in St. Mary School is based on a "first come, first serve" basis. Once classes are filled, all subsequent applicants are placed on a waiting list for future openings in the order they are received. Therefore, it is important to register your child and turn in the necessary enrollment forms as soon as possible.

Please return the following items to the school office:

- Registration Fee of \$125 (Per Child / Per Year)
- Supplies Fee of \$50 (Per Child / Per Year)
- Enrollment Form
- Admission Agreement Form
- Signed Tuition Schedule
- Schedule Agreement
- Pre-School Parent Assessment Sheet
- Food and Environmental Allergy Form
- Medical History
- Emergency Contact Form (LIC 700)
- Comfort Letter & Emergency Kit
- Copy of Child's Immunization Record
- School Photography Authorization Form
- Cubby Box Kit
- Physician's Report - Child Care Centers (completed by Physician)
- Nebulizer Care Consent / Verification
- Notification of Personal Rights
- Notification of Parents' Rights
- Consent for Emergency Medical Treatment
- Consent for Administration of Medications and Medication Chart

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ENROLLMENT FORM

Child's Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Age _____ () Male () Female

Address _____
Number & Street Apt # City Zip Code

Home Phone _____ English Spoken () Yes () No

Other Languages Spoken at Home _____

Siblings at St. Mary School () Yes () No Names _____

Mother's Name _____

Cell Number _____ Work Number _____

Email Address _____

Address (if different from above) _____
Number & Street Apt # City Zip Code

Father's Name _____

Cell Number _____ Work Number _____

Email Address _____

Address (if different from above) _____
Number & Street Apt # City Zip Code

Heard about St. Mary School through:

- () Friend _____
- () Brochure _____
- () Other _____

- () Banner in Front of Church
- () Website

Parent / Guardian Signature

Date Child is to Start

Director's Signature

Date of Registration



ADMISSION AGREEMENT FORM

I have read the "School Handbook" and accept and agree to abide by these policies.

In addition, I understand:

1. I have been informed of the policies and procedures of the school.
2. I have been informed of the goals, philosophy, and beliefs of the school.
3. I have been informed of the services offered.
4. There is a \$125.00 **non-refundable** registration fee and a \$50.00 **non-refundable** supply fee due upon registration.
5. The first tuition payment is due by the first day of school, and all subsequent payments are made on the first of each month.
6. I will be given a 30-day notice prior to any rate changes.
7. Extended day care is provided until 6:00 pm for an additional fee.
8. A late payment of \$30.00 is due with all payments made after the **fifth** of the month.
9. If a student is withdrawn during the year, St. Mary School must be notified in writing at least 30 days prior to withdrawal.
10. The school is not prepared to care for sick children. I will keep my child at home when not well. The administering of medication is as follows:
 - A. All prescription and non-prescription medication shall have an unaltered label and have the child's name and date on it.
 - B. All prescription and non-prescription medication shall be administered only with written approval and instructions from the child's parents and in accordance with label directions prescribed by the child's physician. This will be kept in the child's file.
 - C. St. Mary School will keep a record of the administration of all medications and inform the parent of this record.
11. It is my responsibility to **sign my child in and out** each day. I will furnish the office in writing with the name of each adult person that I authorize to bring or pick up my child on the Enrollment Form. As per the State of California, fines of \$50 per day can be assessed if a child is not properly signed in or out.
12. An unfamiliar individual must present a photo ID to verify their identity to the school staff when picking up a child.
13. My registration will not be complete until all the appropriate forms on the Enrollment Checklist have been completely submitted to the school office with the registration fee and the supply fee.

Parent / Guardian Signature

Date

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SCHEDULE AGREEMENT

Student's Name: _____ Birth Date: _____

Parent/ Guardian: _____ Date: _____

I am registering my child for option checked below:

5 DAYS FULL TIME (OPEN HOURS OF SCHOOL): Monday – Friday

5 DAYS (8:00 AM – 3:00 PM): Monday – Friday

5 HALF DAYS (8:30 AM – 12:30 PM): Monday – Friday

3 FULL DAYS (PLEASE CHOOSE 3 DAYS):

MON TUES WED THU FRI

Please notify the office in advance of a change in schedule.

For the 3-Day Schedule, it is a fixed schedule and cannot change weekly. If you would like to make a change to your schedule, it must be approved by the Director. If one of your scheduled days is on a holiday, it cannot be substituted for another day.

Parent / Guardian Signature

Date

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PRE-SCHOOL PARENT ASSESSMENT SHEET

NAME OF CHILD: _____

DATE OF BIRTH: _____

PLEASE CHECK WHAT APPLIES:

- | | |
|---|--|
| <input type="checkbox"/> Toilet Trained | <input type="checkbox"/> Speaks Understandably |
| <input type="checkbox"/> Feeds Self | <input type="checkbox"/> Seldom Speaks |
| <input type="checkbox"/> Needs Help Feeding Self | <input type="checkbox"/> Speaks in Sentences |
| <input type="checkbox"/> Eats Almost All Foods | <input type="checkbox"/> Does not Speak (Explain Below) |
| <input type="checkbox"/> Eats Very Few Foods | <input type="checkbox"/> Speech Impediment (Explain Below) |
| <input type="checkbox"/> Has Temper Tantrums | <input type="checkbox"/> Initiates Own Actions |
| <input type="checkbox"/> Teases Other Children | <input type="checkbox"/> Follows Requests |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Knows How to Share |
| <input type="checkbox"/> Highly Excitable | <input type="checkbox"/> Is Attentive |
| <input type="checkbox"/> Timid and/or Shy | <input type="checkbox"/> Has Many Interests |
| <input type="checkbox"/> Plays Well With Others | <input type="checkbox"/> Few Interests |
| <input type="checkbox"/> Is "picked on" by Others | <input type="checkbox"/> Has Many Fears |
| <input type="checkbox"/> Overly Aggressive | <input type="checkbox"/> Cries Easily |

MY CHILD NEEDS TO:

- | | |
|---|--|
| <input type="checkbox"/> Adjust to Other Children | <input type="checkbox"/> Relax |
| <input type="checkbox"/> Become Less Active | <input type="checkbox"/> Get Interested in Something |
| <input type="checkbox"/> Become More Active | <input type="checkbox"/> Acquire Manual/Motor Skills |
| <input type="checkbox"/> Become Cooperative | <input type="checkbox"/> Become Self-Reliant |
| <input type="checkbox"/> Other: _____ | |

COMMENTS:

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FOOD AND ENVIRONMENTAL ALLERGY FORM

For your child's safety, St. Mary School would like to maintain a current list of Food and Environmental Allergies for each child in their file. Please complete and sign the form below.

NAME OF CHILD: _____ DATE OF BIRTH: _____

() My child does not have any Food and/or Environmental Allergies.

() My child has Food and/or Environmental Allergies to the following:

ITEM:

ALLERGIC SYMPTOM:

ANY FOOD ITEMS LISTED ABOVE WILL NOT BE SERVED TO YOUR CHILD.

Parent / Guardian Signature

Date

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MEDICAL HISTORY

NAME OF CHILD: _____ DATE OF BIRTH: _____

PLEASE CHECK WHAT APPLIES:

- | | |
|--|---|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Frequent Sore Throat |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Frequent Earaches |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Sunburn |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Homesickness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Plant Poisoning | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Other: _____ |

PLEASE INDICATE THE FOLLOWING DISEASES YOUR CHILD HAS HAD, AND DATES:

- | | | | |
|--|-------------|--|-------------|
| <input type="checkbox"/> Chicken Pox | Date: _____ | <input type="checkbox"/> Scarlet Fever | Date: _____ |
| <input type="checkbox"/> Measles | Date: _____ | <input type="checkbox"/> Polio | Date: _____ |
| <input type="checkbox"/> Tuberculosis | Date: _____ | <input type="checkbox"/> Mumps | Date: _____ |
| <input type="checkbox"/> Rheumatic Fever | Date: _____ | <input type="checkbox"/> Scarlet Fever | Date: _____ |
| <input type="checkbox"/> Whooping Cough | Date: _____ | <input type="checkbox"/> Rubella | Date: _____ |
| <input type="checkbox"/> Other: | _____ | | |

Specific Activities to be Encouraged: _____

Specific Activities to be Restricted: _____

Recent Operations or Serious Injuries: _____

Is your Child under Special Medication: _____

INSTRUCTIONS FOR ST. MARY SCHOOL

Should my child require special medication during school hours, I will send the medication to the school office with written instructions from a physician. I hereby authorize the school office staff to administer it, according to the written instructions indicating dosages and time schedules (I must complete the Consent for Medication for Administration of Medication Form for further instructions).

Parent / Guardian Signature

Date



EMERGENCY KIT & COMFORT NOTE

In order to be best prepared for Emergency Situations that may occur during the school day, such as earthquakes, we ask that your child have an Emergency Kit. Below you will find what is needed to be put in a **GALLON SIZE ZIPLOC BAG**. Included in the bag will be a copy of the "Health and Emergency Form" as well as a "Comfort Letter" for each child. The policy at St. Mary School is that, in the event of an emergency, children will be kept at school until a designated individual picks them up.

St. Mary School will provide Water, First Aid Necessities and FlashLights.

KITS ARE TO CONTAIN THE FOLLOWING:

- () One Change of Clothing
- () One Space Blanket (this item can be purchased at Sporting Good Stores)
- () Three Cans of Protein Food
- () 3-5 Favorite Snacks that keep for a long period of time (i.e.: roll ups, granola bars, etc.)
- () A picture of the family
- () 3x5 Card - Name and telephone number of an out of state contact person
- () One Travel Size Pack of Baby Wipes
- () One Favorite Small Toy or Book
- () One Comfort Letter
- () 4x6 Card - with your student's name, telephone number and address. This should be placed in the bag and **clearly visible from the outside.**

COMFORT NOTE

A short note to your child from you. If there are any nicknames, Bible verses or favorite sayings, please add this. Notes for children will reassure them that everything will be ok, and you will be there shortly to pick them up. Please remind your child to pray, be obedient to those in charge and show their best manners.

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SCHOOL PHOTOGRAPHY AUTHORIZATION FORM

NAME OF CHILD _____

St. Mary School occasionally take photos of the students during school time (i.e.: pictures during class time, play time, school events, etc.). We will be including these pictures in our annual yearbook, as well as on social media, the school website, our banners, brochures or other types of school related advertising. There will be NO individual photography done; only group photos will be taken. If you agree to waive all rights to this issue, please check the "I AGREE" box below.

() **I AGREE** to have pictures of my child taken during school time, to be used as stated clearly above.

() **I DISAGREE** to have pictures of my child taken during school time, to be used as stated clearly above.

Parent / Guardian Signature

Date

Parent / Guardian Name

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CUBBY BOX KIT

The following is a list of items your child will need to bring to school. Please make sure all items are labeled with your child's FIRST & LAST NAME.

- () One Change of Clothing (Shirt, Pants, Socks, etc.)
- () One Warm Jacket or Sweater
- () One Small Blanket
- () Extra underwear, or pull-ups
- () One Travel Size Pack of Baby Wipes
- () One Spill Proof Cup with Lid - FIRST & LAST NAME WRITTEN ON CUP
(Replace Every 3 Months)
- () LARGE Zip Lock Bag - FIRST & LAST NAME WRITTEN ON BAG

**** BLANKET GOES HOME EVERY FRIDAY TO BE WASHED ****

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: _____
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.

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

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE
LAST					MIDDLE
FIRST					()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME					BUSINESS TELEPHONE
LAST					MIDDLE
FIRST					()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PERSON RESPONSIBLE FOR CHILD					HOME TELEPHONE
LAST NAME					MIDDLE
FIRST					()
					BUSINESS TELEPHONE
					()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
---	------

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

DATE OF ADMISSION	DATE LEFT
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

_____ 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
()

**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

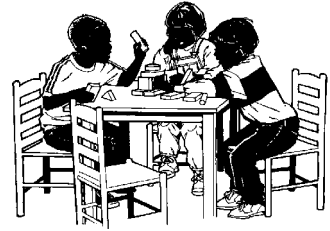
HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

Community Care Licensing



CHILD CARE CENTER



NOTIFICATION OF PARENTS' RIGHTS

THIS NOTICE MUST BE POSTED IN A PROMINENT, PUBLICLY ACCESSIBLE AREA OF THE CHILD CARE CENTER

AS A PARENT/AUTHORIZED REPRESENTATIVE, YOU HAVE A RIGHT

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.
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.

<http://www.cclcd.ca.gov>

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

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.

Licensing Office Name: LANW Child Care
Licensing Office Address: 300 N Continental Blvd, Suite # 290A, Ms 29-13
El Segundo, CA 90245
Licensing Office Telephone Number: (424) 301-3077



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:

LANW Child Care

NAME

300 N. Continental Blvd. #209

ADDRESS

El Segundo

CITY

90245

ZIP CODE

(424)301-3077

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)

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

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

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

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

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

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

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