

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

Department of Social Services

ADDRESS

2580 N. First Street, Suite 300 MS 29-08

CITY

San Jose

ZIP CODE

CA

AREA CODE/TELEPHONE NUMBER

408-324-2148

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)

Montecito Preschool

(PRINT THE ADDRESS OF THE FACILITY)

1468 Grant Road, Los Altos, CA 94024

(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: Department of Social Services - Community Care Licensing

Licensing Office Address: 2580 N. First St, Ste. 300 MS29-08, San Jose, 95131

Licensing Office Telephone #: 408-924-2148

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.megaonline.gov

LIC 225 (10/07)

(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.

Monteilla School

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgment 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.megaonline.gov

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children cannot by law be given an exemption that would allow them to own, live in or work in a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- * The crime
- * What they have done to change their life and obey the law
- * Whether they are working, going to school, or receiving training
- * Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is http://ccl.dss.cahwnet.gov/RegionalOf_1029.htm

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

FAX: 650-968-2052

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:

Feeding: _____ Allergies/medication: _____
 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-208.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTaP/DTaP (DIPHTHERIA, TETANUS AND ACELLULAR PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
IB MENINGITIS (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: _____

MEDICAL AND EMERGENCY INFORMATION

MONTECITO SCHOOL

1468 GRANT RD, LOS ALTOS, CA 94024

PHONE: (650) 968-5957; FAX: (650) 968-2052

EMAIL: admin@montecitopreschool.com; WEBSITE: www.montecitopreschool.com

CHILD'S/ENROLLEE'S FULL NAME: _____

EMERGENCY & MEDICAL INFORMATION:

PHYSICIAN'S NAME: _____ PHONE(S): _____

DENTIST'S NAME: _____ PHONE(S): _____

As the parent, agency representative or legal guardian, I hereby give consent to Montecito School to provide all emergency dental or medical care prescribed by a duly licensed physician or dentist for _____ (child's name). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of dependent/enrollee/child.

SIGNATURE: _____ DATE: _____

CHILD'S/ENROLLEE'S ALLERGIES (IF APPLICABLE):

Food(s): _____

Other Allergies: _____

SEVERITY: Mild? ____ Severe? ____ Life Threatening? ____

Please describe on the Teacher Information Sheet what a typical allergic reaction has been in the past and discuss allergies with your child's teachers.

Does the child require medication to be with him/her? Y ____ N ____

If yes, please see the Office for Medication Release Form & Allergy Action Plan to be completed by you and your child's physician & returned to School with the medication.

EMERGENCY CONTACT & PICK-UP INFORMATION:

Please list four (4) local contacts/people who may be contacted in case of an emergency AND the name(s) of person(s), other than parent(s) or guardian(s) listed above, authorized to pick up child/Enrollee from Montecito Preschool. Children WILL NOT be allowed to leave with any other person without written authorization from parent or guardian.

NAME:	CITY:	PHONE(s):	RELATIONSHIP:
1.			
2.			
3.			
4.			

Please provide
a photo
from
shoulders up

Room Code
(Teacher to complete)

CHILD'S NAME: _____

CHILD'S ADDRESS: _____

HOME TELEPHONE: _____

OUT OF STATE EMERGENCY CONTACT PERSON
This number will only be used if the child is injured or
has not been picked up within 4 hours.

NAME: _____

NUMBER: _____

Please return this card to your teacher.

Montecito Preschool
DISASTER INFORMATION CARD
(please print clearly)

(Father's name, Work phone, Cell phone)

(Mother's name, Work phone, Cell phone)

(Physician's name, Work address & Work phone)

ALLERGIES: _____

Under Emergency Conditions, the following local people may take my child from
Montecito Preschool:

- | | |
|--|--|
| 1. _____
(Name, phone and cell phone) | 3. _____
(Name, phone and cell phone) |
| 2. _____
(Name, phone and cell phone) | 4. _____
(Name, phone and cell phone) |

In the event of an emergency, Montecito Preschool has my permission to provide
all dental or medical care prescribed by a duly licensed physician or dentist for

Child's name

This care may be given under whatever conditions are necessary to preserve life,
limb or well being of my dependant.

Parent's Signature

Montecito School

TEACHER INFORMATION SHEET

CHILD'S NAME: _____

CHILD'S CLASS: _____

BIRTHDATE: _____

MOTHER'S NAME: _____

OCCUPATION: _____

FATHER'S NAME: _____

OCCUPATION: _____

HEALTH & DEVELOPMENT INFORMATION:

Does child have any food or other allergies? _____ If so, please list the foods/allergens: _____

Please describe what a typical allergic reaction has been in the past. _____

Dietary restrictions (vegetarian? religious/cultural preferences?): _____

What other illness(es), operation(s), injury(ies), or condition(s) has child had? _____

Was your child born prematurely? _____ If so, how premature? _____ (Mos./wks.)

At what age did child begin walking? _____ mos.; talking? _____ mos.

Please describe your child's typical sleep & napping patterns: _____

Please describe your child's typical eating patterns & preferences: _____

CHILD'S QUESTIONNAIRE:

Has child ever attended a nursery school? _____ If so, for how long? _____

Have caregivers other than parent(s) or guardian(s) cared for child? _____

Will your child be in the care of someone else before or after school? If so, please elaborate. _____

Will your child attend another school in conjunction with Montecito? If so, please elaborate. _____

Who is the child living with? _____

What is the primary language spoken at home? _____

Does your child have any speech delays? _____

Child's Name _____

Please list the other members of your household including parents, grandparents, other children in the family, the children's ages and any extended family member(s) and roommates. Pets are family too!

Have there been any events in your child's life that have affected him/her such as divorce, death, illness or a move? If so, please elaborate. _____

How does your child get along with his/her sisters and brothers? _____

How does your child get along with his/her peers? _____

How does your child handle separation? _____

Does your child need help with: Dressing himself/herself? _____

Going to the bathroom? _____

Any special words or gestures used to describe going to the bathroom? _____

What do you find most effective in redirecting and disciplining your child? _____

How would you describe/evaluate your child's personality? _____

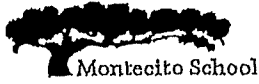
Describe your child's strengths and weaknesses. _____

Please share any special customs or traditions your family honors or celebrates. _____

What do you hope your child will learn during their preschool year? _____

Additional comments _____

Thank you for completing this form. This questionnaire will be given to your child's teacher and also put in his/her office file. This information is only used by the teacher in order to better understand your child's needs and personality.



Allergy Action Plan/Anaphylactic Reaction Emergency Procedure Form

STUDENT NAME _____ DOB _____ CLASSROOM _____

ALLERGY TO _____

ASTHMATIC YES* NO *HIGHER RISK FOR SEVERE REACTION

SIGNS OF AN ALLERGIC REACTION INCLUDE THE FOLLOWING SYMPTOMS:

PLEASE CHECK THE SYMPTOMS THAT MAY APPLY TO YOUR CHILD

- | | | | | | |
|---------|--|--|--|------------------------------------|-----------------------------------|
| MOUTH | <input type="checkbox"/> Itching | <input type="checkbox"/> Tingling | <input type="checkbox"/> Swelling of Lips, Tongue or Mouth | | |
| SKIN | <input type="checkbox"/> Hives | <input type="checkbox"/> Itchy Rash | <input type="checkbox"/> Swelling of face or extremities | | |
| STOMACH | <input type="checkbox"/> Nausea | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| THROAT* | <input type="checkbox"/> Tightening of Throat | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Hacking Cough | | |
| LUNG* | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Repetitive Coughing | <input type="checkbox"/> Wheezing | | |
| HEART* | <input type="checkbox"/> Weak or thready pulse | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pale skin | <input type="checkbox"/> Blueness |
| OTHER* | _____ | | | | |

* Potentially life-threatening.
The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a life-threatening situation.

PROCEDURE TO FOLLOW:

If child has been stung or has a severe allergic reaction, Staff will immediately administer:

Epinephrine: Inj ect intramuscularly EpiPen® EpiPen® Jr Twinject® 0.3mg
Twinject® 0.15mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

Asthma Inhaler: _____
medication/dose/route

Give both the EpiPen® and the _____ medication simultaneously. Yes No

Give _____ medication and observe for _____ minutes. However, if anaphylactic symptoms (above) occur give the EpiPen®

Important: Asthma Inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

IF AN EPIPEN® HAS TO BE ADMINISTERED:

1. Call 911. Notify them that the child has been given epinephrine for a possible anaphylactic reaction.
2. Call Parents.
3. Get Emergency Card.
4. Keep child lying down with feet elevated. Keep warm. Ensure adequate airway. Child may become drowsy following medication.
5. If breathing stops at any time during procedure, initiate rescue breathing immediately. If breathing and pulse stops, initiate CPR immediately.
6. Stay with child until Parents or Paramedics arrive. If Parents are unavailable, a staff member will accompany child to hospital with a copy of the Emergency Card.

Parent must provide all medication that will not expire during the current school year on or before the first day of attendance.

Parent Name _____ Ph 1: _____ Ph 2: _____

Parent Name _____ Ph 1: _____ Ph 2: _____

Parent Signature (required) X _____ Date: _____

Physician Name: _____ Ph: _____

Physician Signature (required) X _____ Date: _____