

BREA OLINDA UNIFIED SCHOOL DISTRICT
DEPARTMENT OF CHILD DEVELOPMENT SERVICES
(714) 990-7527

Dear Parents,

Enrollment is now open for BOUSD Summer Camp 2017 and for all Child Development programs for the 2017-2018 school year. Summer Camp will operate June 19th-August 18th. **CAMP IS CLOSED TUESDAY, JULY 4TH. ALL PROGRAMS WILL BE CLOSED AUGUST 21-28 IN PREPARATION FOR THE FALL.** Child Development centers will re-open on August 29, 2017, for the first day of school.

Fee-based Preschool Camp will be held at MARIPOSA. You will find all of the registration materials enclosed. Preschool Summer Camp registration will **ONLY** be accepted at our main office located at Arovista Elementary School in Room 28. Registration will begin on Monday, April 17th at 9am - first come, first served. We have a limited number of spots available per week.

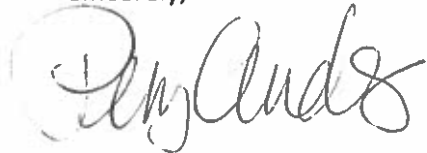
Your registration is not complete unless you have completed all registration materials, and have included the non-refundable holding deposit for each week of camp.

Summer Camp registration will close to current families on Friday, May 5th. We kindly request that you turn these documents in on time so that we may plan accordingly. New family registration will begin in mid May 2017, and we want to ensure that your child will have a spot in our program.

If you have any questions, please call the Child Development Services main office at 714-990-7527.

We look forward to having you and your child as a part of our program this upcoming year.

Sincerely,



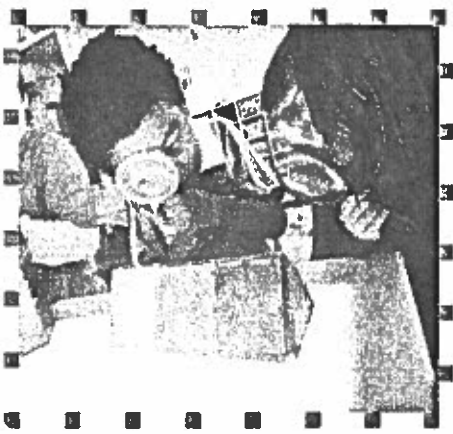
Penny Andrews
Coordinator, Preschool Programs
Child Development Services
pandrews@bousd.us

Brea Olinda Unified School District Preschool Summer Camp 2017

UNDER the

STEAM

Science • Technology • Engineering • Arts • Mathematics



Open to
children
ages 3-5
years of
age.

Our preschool summer camp promotes 21st Century Learning by incorporating STEAM (science, technology, engineering, the arts, and mathematics) activities throughout the day.

SUMMER WEEKLY THEMES

Swim in the School of Success
Dive in and Explore
Let's Go to the Beach
How Salty is the Sea...
Water, Water, Everywhere
Fishing Around
Guess what sea animal I Am?
Fish in the Water
Under the Sea
Making a Splash into Preschool

For more information contact the Child Development Administrative Office at (714) 990-7527.

BOUSD SUMMER DAY CAMP REGISTRATION 2017 – PRESCHOOL

As the parent or legal guardian of the below named child, I understand, agree to and/or acknowledge the following:

Tuition will be paid on a monthly basis, and is due three times throughout the summer – June 9th (for June), June 30th (for July), July 28th (for August). Children may not show up to camp each week unless tuition has been received. There will no pro-rations or refunds for days in which children do not attend camp. All tuition is non-refundable. Parents must pay monthly, or through arrangements made with the Child Development Administrative Assistant.

I have indicated which session(s) my child will be attending throughout the summer by signing the "signature" box for the requested week(s). I WILL BE BILLED for EACH week that I sign up for – even if my child does not attend - unless arrangements have been made with the administrative office. **One week notice is required when making any changes to the contract.**

\$10 HOLDING FEE for each week that you are signing up for must accompany this registration form. This fee is NON REFUNDABLE and NON TRANSFERABLE.

Children cannot attend any BOUSD Child Care program unless all accounts are paid up to date at all times. Summer balances must be paid off before your child attends in the fall.

SESSION	FEES	SIGNATURE	SESSION	FEES	SIGNATURE
Session 1 June 19-23	\$10 + \$165		Session 6 July 24-28	\$10 + \$165	
Session 2 June 26-30	\$10 + \$165		Session 7 July 31-August 4	\$10 + \$165	
Session 3 July 3-7	\$10 + \$155		Session 8 August 7-11	\$10 + \$165	
Session 4 July 10-14	\$10 + \$165		Session 9 August 14-18	\$10 + \$165	
Session 5 July 17-21	\$10 + \$165				

Child's Name: _____ Tshirt Size: _____

Camp Location: Mariposa Preschool Camp Fall School Location: _____

Parent's Name: _____ Signature: _____

**BREA OLINDA UNIFIED SCHOOL DISTRICT
CHILD DEVELOPMENT SERVICES**

PRESCHOOL REGISTRATION PACKET

SUMMER

Early Learning Centers

Full-time Programs:

Mariposa

ALL forms & payments must be received in order to enroll & start school

<p>____ Rate Sheet</p> <p>____ Admission Agreement</p> <p>____ Registration Form (ALL lines completed)</p> <p>____ BOUSD Date Enrollment Form</p> <p>____ BOUSD Language Questionnaire</p> <p>____ Off Campus Permission</p> <p>____ Photo Release</p> <p>____ Identification & Emergency Information</p> <p>____ Personal Rights</p> <p>____ Parent's Rights</p> <p>____ Registration Fee</p> <p>____ Tuition Fee</p>	<p><u>MEDICAL FORMS</u></p> <p>____ Birth Certificate</p> <p>____ Consent for Emergency Medical Treatment</p> <p>____ Parents' Health History</p> <p>____ Physician's Report (MUST be within 12 months of school entry)</p> <p>____ Immunization Record (MUST be official copy)</p> <p>____ Student Health Survey</p> <p>____ Screening Consent Form</p> <p>____ Participant Authorization Form</p> <p><u>IF NEEDED:</u></p> <p>____ Medication Administration Form (if needed during school hours)</p> <p>____ Medication brought to School Readiness Nurse before 1st day of class</p>
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ADMINISTRATIVE OFFICE

Arovista Elementary School – Room 28
(714) 990-7527

Department Director: Chris Becerra
Administrative Assistant: Kayleen Farrer
Program Technician: JoAnne Warren
State Preschool Coordinator: Penny Andrews
Early Learning Specialist: Amy Shultz
School Readiness Nurse: Theresia Guillow

****Registration materials must be received a minimum of two business days prior to the start of the program**

BREA-OLINDA UNIFIED SCHOOL DISTRICT
Department of Child Development Services
Preschool Summer Admission Agreement

As the parent or legal guardian of the below named child, I understand, agree to and/or acknowledge the following:

- A. I acknowledge that I have reviewed a copy of the Parent Handbook and will comply with the policies set forth (handbook is available on the BOUSD website).
- B. Field trips, either by walking or in BOUSD vehicles or chartered buses, are a part of Child Care program activities. No additional permission slips will be required.
- C. BOUSD staff and volunteers are not allowed to baby-sit or transport children at any time outside of the BOUSD program.
- D. I am not to leave my child at the BOUSD Program Center unless a BOUSD staff or volunteer is there to receive and supervise my child.
- E. Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. (Please do not put staff in a position where they have to make this judgment call.)
- F. BOUSD is mandated by state law to report any suspected child abuse or neglect to the appropriate authorities for investigation.
- G. BOUSD may terminate my child's enrollment for any of the following reasons:
- Emergency names and phone numbers are incorrect
 - Parent is late picking up child after Program Center closes
 - Non/late/NSF payment of fees
 - Failure to adhere to the sign-in/sign-out policies
 - Failure to notify the BOUSD Program Center that child will be absent
 - Child leaving the Program Center without authorized written permission
 - Behavior that is continually disruptive or dangerous to others and/or self
 - Behavior that is destructive to property and/or refusal to replace said property
 - Any single incident that is deemed by the Program Center Director to be dangerous, harmful or disruptive
 - Harassment, violent behavior or threat of such behaviors against a staff person or other member by parent/guardian or persons associated to the child (family member, family friend etc.)
- H. Program participation requires a BOUSD tuition in good standing and that non-payment of fees will result in my child not being allowed to participate in the program and could result in legal referral with additional costs to myself. I further understand there is an administrative processing fee for any payment returned by my bank or credit account. Refunds and/or credits are not given for any day in which a child does not attend the program including school closures and seasonal breaks.
- I. BOUSD and the staff employed by the BOUSD will not become involved in any custodial disputes between parent/guardian. If BOUSD documents are requested, the court must request them. The staff's responsibility is to provide a safe environment for children.
- J. I understand that I am required to give 30-day written notice when terminating from the BOUSD Child Care Program. If **30-day written notice** is not given, I will not receive a refund or credit. Registration fees are non-refundable.
- K. The Community Care Licensing Division of California Department of Social Services (Section 101200) has the authority to interview children or staff and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any child(ren) or any staff member and for the examination of all records relating to the operation of the facility. The licensing agency has the authority to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect, or inappropriate placement.

Child's Name

School

Parent/Guardian Signature

Date

BOUSD Representative Signature

Date

BREA OLINDA UNIFIED SCHOOL DISTRICT
CHILD CARE REGISTRATION FORM

All spaces must
be completed!

circle one)
SCHOOL: (Preschool A/CH/L/M/O) A CH F L M O TC GRADE: _____ BIRTHDATE: _____

CHILD'S NAME _____ Male Female
(LAST) (FIRST) (MI) (NICKNAME)

FAMILY SURNAME _____ FATHER'S 1ST NAME _____ MOTHER'S 1ST NAME _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME # _____ CHILD'S LEGAL GUARDIAN _____ MARITAL STATUS _____
FATHER'S MOTHER'S

CELL # _____ CELL # _____ E-MAIL ADDRESS _____

Child lives with: Father Mother Guardian Stepparent
Are there any legal or custodial restrictions of which we need to be aware? Yes No If yes, please attach a copy of the current custody order.
Would you like to be included in our Parent Directory? Yes No

FATHER'S EMPLOYER _____ ADDRESS _____

WORK HOURS _____ TO _____ TELE # _____ EXT _____

MOTHER'S EMPLOYER _____ ADDRESS _____

WORK HOURS _____ TO _____ TELE # _____ EXT _____

PERSON TO CALL IN CASE OF EMERGENCY _____ TELE # _____ hm
NOTE: We always call the parents first, please list a "next best" person) _____ cell

RELATIONSHIP TO CHILD _____

NAMES OF PERSONS AUTHORIZED TO TAKE YOUR CHILD HOME FROM CENTER - INCLUDE THREE PERSONS IN ADDITION TO THE PARENT(S) (must be over 18 years of age) Your child will not be permitted to leave with any person without written authorization of parent or guardian.

NAME _____ ADDRESS _____ TELEPHONE # _____

NAME _____ ADDRESS _____ TELEPHONE # _____

NAME _____ ADDRESS _____ TELEPHONE # _____

RELEASE NOTE: In case of illness or accident at school when you are unable to contact me by telephone, I give my legal consent to have my child taken to the following physician:
Family Physician: _____ Phone Number: _____

INFORMED CONSENT: BREA OLINDA UNIFIED SCHOOL DISTRICT IS EXTREMELY PROUD OF ITS INSTRUCTIONAL PROGRAM IN ATHLETICS, PHYSICAL EDUCATION AND ACTIVITIES. EVERY PRECAUTION AND SAFEGUARD IS TAKEN TO INSURE THE SAFETY OF OUR STUDENTS. HOWEVER, PRECEDENTS SET BY RECENT LITIGATION HAVE CREATED A DEMAND ON SCHOOL DISTRICTS TO WARN STUDENTS OF THE RISK INVOLVED IN ATHLETIC/ACTIVITIES PARTICIPATION, AN INJURY, PARALYSIS, AND IN SOME EXTREME CASES, DEATH CAN OCCUR IN ANY DEAVOR. YOUR SIGNATURE ON THIS CARD INDICATES THAT YOU HAVE READ THIS STATEMENT.

DISASTER EVACUATION INSTRUCTIONS

In the event of a disaster, state law authorizes school authorities to release students to parents/guardians or other adults as approved by parents. Telephones may be useless in a disaster such as an earthquake, and you may be unable to come to school to obtain the release of your child. Therefore, please list other persons (neighbors, friends, etc.) who could come to school for your child. This list will ONLY be used in the event of a disaster evacuation. In a disaster evacuation, my daughter/son may be released to any adult listed below.

NAME	RELATIONSHIP	TELEPHONE #
_____	_____	_____
_____	_____	_____

Name of out-of-state contact: _____

Parent Signature: _____

BREA OLINDA UNIFIED SCHOOL DISTRICT DATA ENROLLMENT FORM

Legal Last Name of Student		Legal First Name		Middle Name
Address (No., Street)		City	Zip	Home Phone
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Birth Date	Birth City	Birth State	Birth Country
Prior Schools Attended (Name/District)		Phone	Dates Enrolled	
Address		City	State	Zip
Prior Attendance in Brea Olinda Unified School District? Yes <input type="checkbox"/> No <input type="checkbox"/>			Dates Enrolled in BOUSD:	
U.S. Entry Date		First USA School Enter Date	First California School Enter Date	

Child is living with: Father Mother Legal Guardian/Foster Parent Authorized Caregiver

	Mark Appropriate Box: <input type="checkbox"/> Father <input type="checkbox"/> Stepfather	Mark Appropriate Box: <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother
	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Caregiver	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Caregiver
Name		
Address		
Home Phone	() ()	() ()
Cell Phone	() ()	() ()
Work Phone	() ()	() ()
Parent's E-Mail		
Parent Education Level	<input type="checkbox"/> (1) Not a high school graduate (Less than 12th grade)	<input type="checkbox"/> (1) Not a high school graduate (Less than 12th grade)
	<input type="checkbox"/> (2) High school graduate (Completed 12th grade)	<input type="checkbox"/> (2) High school graduate (completed 12th grade)
	<input type="checkbox"/> (3) Some college	<input type="checkbox"/> (3) Some college
	<input type="checkbox"/> (4) College graduate	<input type="checkbox"/> (4) College graduate
	<input type="checkbox"/> (5) Graduate school/Post graduate training	<input type="checkbox"/> (5) Graduate school/Post graduate training
	<input type="checkbox"/> (6) Decline to state	<input type="checkbox"/> (6) Decline to state

Ethnicity:
 Is student Hispanic or Latino? Yes No
 Please select race from the list below (check all that apply/must select at least one)

<input type="checkbox"/> American Indian/Alaska Native (100)	<input type="checkbox"/> Chinese (201)	<input type="checkbox"/> Japanese (202)	<input type="checkbox"/> Korean (203)	<input type="checkbox"/> Vietnamese (204)
<input type="checkbox"/> Asian Indian (205)	<input type="checkbox"/> Laotian (206)	<input type="checkbox"/> Cambodian (207)	<input type="checkbox"/> Other Asian (299)	<input type="checkbox"/> Hawaiian (301)
<input type="checkbox"/> Guamanian (302)	<input type="checkbox"/> Samoan (303)	<input type="checkbox"/> Tahitian (304)	<input type="checkbox"/> Other Pacific Islander (399)	
<input type="checkbox"/> African-American (800)	<input type="checkbox"/> White (700)	<input type="checkbox"/> Filipino (400)		

If multiple races, please identify primary race: _____

My child receives the following services (check all that apply)

<input type="checkbox"/> Special Education (IEP)	<input type="checkbox"/> 504 Plan	Retention: <input type="checkbox"/> Yes (grade level _____) <input type="checkbox"/> No
<input type="checkbox"/> Resource Specialist Program (RSP)	<input type="checkbox"/> Special Day Class	
<input type="checkbox"/> Speech and Language	<input type="checkbox"/> Other	
	<input type="checkbox"/> English Learner (EL)	
	<input type="checkbox"/> GATE	

Language child first spoke: _____ Language adult uses to speak to child: _____
 Language child uses at home: _____ Language spoken by adults in home: _____

Current court papers (Custody, Restraining Orders, etc.) must be on file in the school office. Does this apply to your child? Yes No

SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE

Birthdates Verified: _____ Verification of Address: _____ Method: _____
 Birth Certificate Number: _____ Date Entered: _____ Date Withdrawn: _____
 School: _____ Grade: _____ Teacher: _____

Parent/Guardian Signature: _____ Date: _____

BREA OLINDA UNIFIED SCHOOL DISTRICT

**LANGUAGE QUESTIONNAIRE
LANGUAGE OTHER THAN SPANISH
(To Be Placed in Student's CUM LEP File)**

Student's Name _____ ID Number _____ DOB _____

Primary Language _____ Birthplace _____ US Enter Date _____

	YES	NO
1. Has student been in school in another country? If yes, how long? _____		
2. If yes, in what language was student being instructed? _____		
3. Has student been enrolled in another school (include pre-school) in the U.S.? If yes, what was the language of instruction? _____		
4. Are there any older brothers or sisters living with student at home? If yes, indicate primary language spoken. _____		
5. Can the student read, write, and do math in his/her primary language? If yes, at what estimated level? _____		
6. Are books, magazines and/or television at home available in the primary language? If yes, does the student enjoy looking at them or reading them? _____		
7. Are there books, magazines and/or television at home available in English? If yes, does the student enjoy looking at them or reading them? _____		
8. What language does student use when interacting/socializing with others who speak the same primary language? _____		
9. Did your child take the CELDT this year? _____ Do you have the results? _____		

The questions can be answered through the use of a translator that parents or school provides.

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

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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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

Community Care Licensing

ADDRESS

750 The City Drive, Suite 250

CITY

Orange

ZIP CODE

92868

AREA CODE/TELEPHONE NUMBER

714) 703-2800

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: Community Care Licensing

Licensing Office Address: 750 The City Drive, Suite 250, Orange CA 92868

Licensing Office Telephone #: 714) 703-2800

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 895 (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

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
()

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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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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?*
	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST
	DINNER	LUNCH
		DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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

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)
BOUSD - Olinda Early Learning Center. This Child Care Center/School provides a program which extends from 7 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to 6:00 a.m./p.m., 5 days a week.

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

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

(TODAY'S DATE)

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

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____
Vision: _____ Insect stings: _____
Developmental: _____ Food: _____
Language/Speech: _____ Asthma: _____
Dental: _____
Other (include behavioral concerns): _____
Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /			
HIB 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: _____ Date of Physical Exam: _____
 Address: _____ Date This Form Completed: _____
 Telephone: _____ Signature _____

Physician Physician's Assistant Nurse Practitioner

**BREA OLINDA UNIFIED SCHOOL DISTRICT
Preschool Student Health Survey**

Child's Name: _____ Date of Birth: _____

Sex: _____ School: _____

Any medication used during school hours will be kept locked in the classroom and must be in the original container with a medication form filled out by physician and parent. Forms and medication must be brought to the School Readiness Nurse in the Child Development Services office. All medication forms can be found on the school district website or in our office.

Does your student currently have: (Please mark EACH item)

	YES	NO		YES	NO
Environmental Allergies Please list:			Severe Allergy (requiring Epi-Pen) Please list:		
Asthma or breathing problems			Hospitalizations (specify)		
Attention-Deficit/ Hyperactivity Disorder			Physical problems (limited physical activity)		
Diabetes			Seizures/Epilepsy		
Hearing problems			Surgeries		
Heart problems			Vision problems		

Does your student have any life threatening allergies that requires medication at school? If yes, please list condition(s), medication(s) and doses:

If your child is allergic to any medications, please list below:

Are there any other physical conditions that the school should be aware of?

Has your student ever had serious illnesses or injuries other than those already noted that would affect performance/activities at school? What? When? Explain:

Are there any special things you want us to know about your child? (i.e., fears, eating likes/dislikes, social/emotional difficulties, etc.)

Parent Signature: _____ Date: _____

Participant Authorization Form – Primary Caregiver and Child

As the parent or legal guardian of _____
(Child's name as listed on birth certificate) (First) (Middle) (Last)

I agree to allow (BOUSD) to share information about me and my child with the Children and Families Commission of Orange County, trusted organizations that are partners with the Commission, and Commission representatives. The information will be used to help the Commission learn how the services it funds help children prepare for school and to help plan for future services.

The information about both me and my child may include the following:

- Name, date and place of birth, gender, ethnicity, primary language, current address, services we received, results of the services received
- Medical information (medical/dental care utilization, birth weight, immunizations, etc.)
- Educational information (preschool services, special needs services, etc.)
- Developmental information (developmental screening, assessment, and services)

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by marking the box below:

I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code §5328, et seq)

I understand that:

- I should answer only those questions with which I am comfortable – I do not have to answer every question asked;
- Providing the information may involve a 10-minute interview when I start the program, when I complete the program and annually while I am receiving services from this program;
- Reports prepared from this information will not identify me or my child in any way;
- My approval to share this information will end on my child's nineteenth (19) birthday, and the information will be removed from the computer system. I also understand that I may cancel this authorization at any time by submitting a Request to Remove Confidential Information Form or by writing to (BOUSD) or the Children and Families Commission of Orange County at 17320 Red Hill Avenue, Suite 200, Irvine, California, 92614. My child may also cancel this authorization in writing when he/she is at the age in which the law allows him/her to act on his/her own;
- Signing this Authorization is voluntary; if I choose not to sign this Authorization, my child and I will still receive services from (BOUSD).
- This Authorization does not include sharing information that may identify me or my child related to participation in alcohol or drug treatment programs or criminal arrests or convictions. Such information may only be shared if I sign a separate, specific written consent form;

Participant Authorization Form – Primary Caregiver and Child (con't)

2

- The security and protection of my private information are very important to (*organization*). The only people who will be able to see my personal identifying information are those that provide me services and the Commission's computer consultants, who need this information in order to delete and/or correct records. The Commission's staff and its partners who have access to our personal identifying information have signed an agreement to maintain its privacy.
- After some health information is shared it may no longer be protected by the Federal Privacy Rule, but may still be protected by other state and federal laws.
- A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this form if I ask for one.

Signature of parent or legal guardian: _____

Date: _____

Please print name clearly: _____

Relationship to child: _____

Child's birth date: _____

OR

I do not want to share information about me and my child with the Children and Families Commission of Orange County, trusted organizations that are partners with the Commission, and Commission representatives. (Please check the box and fill out information below).

Signature of parent or legal guardian: _____

Date: _____

Please print name clearly: _____

Relationship to child: _____

Child's birth date: _____

Thank you!



Children & Families
Commission of Orange County

Revised 7/2012

BREA OLINDA UNIFIED SCHOOL DISTRICT

OFF CAMPUS TRIP PERMISSION FORM

I hereby give my consent for the student named below to participate in off campus sports/activities sponsored by the Brea Olinda Unified School District. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorize the medical agency to render treatment. In addition, I am aware of Education Code Section 35330, which provides that all persons making a field trip or an excursion are deemed to have waived all claims against the district for injury, accident, illness or death occurring during or by reason of the trip or excursion.

In addition, I hereby waive all claims against the Brea Olinda Unified School District or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion, whether or not such injury, accident, illness, or death is caused by negligence.

NOTE TO PARENTS: Students riding the school bus to an activity are expected to return by bus. Any deviation from this rule must be approved by parent and sponsoring teacher prior to the event. Although most activity transportation is done by bus, some events and groups require the use of private cars. The Brea Olinda Unified School District does not carry medical or dental insurance for students injured on school premises while under school jurisdiction or through school district activities.

Name of Student _____ School of Attendance _____

Address _____ City _____

Home Phone _____ Grade _____ Birthdate _____

Father's Wk # _____ Cell # _____ Mother's Wk # _____ Cell # _____

Emergency Name _____ Telephone # _____

Doctor's Name _____ Telephone # _____

Does the student have any injury or physical condition that should be watched?

YES _____ NO _____ Please explain: _____

Parent/Guardian Signature _____ Date: _____

**BREA OLINDA UNIFIED SCHOOL DISTRICT
PHOTO RELEASE FORM**

A request has been made to have your student photographed by BOUSD Department of Child Development Services for pictures of activities for Summer 2017 and School Year 2017-2018.

Please complete and sign the form below.

(PLEASE RETURN THIS PORTION TO
THE BOUSD DEPARTMENT OF CHILD DEVELOPMENT SERVICES)

I give my permission for _____
to have his/her picture taken for _____ pictures of activities _____
for _____ Summer 2017 and School Year 2017-2018 _____

I do not give my permission for _____
to have his/her picture taken for _____ pictures of activities _____
for _____ Summer 2017 and School Year 2017-2018 _____

***If you choose not to let your child be photographed, please be sure to make your child aware of your decision.**

Parent/Guardian Signature _____

Student Name _____

School of Attendance _____

BREA OLINDA UNIFIED SCHOOL DISTRICT

TRANSPORTATION PASSENGER PROFILE

Participant's Name: _____

Site/Location Name: _____

Sex:

Male

Female

Height: _____

Birthdate: _____

Age: _____

For identification purposes, please attach a recent photo of your child:

