

**BREA OLINDA UNIFIED SCHOOL DISTRICT  
DEPARTMENT OF CHILD CARE SERVICES**

**SCHOOL AGE DIVISION  
REGISTRATION PACKET**

ADMINISTRATIVE OFFICE

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

Locations:

Arovista Elementary School  
Country Hills Elementary School  
Fanning Elementary School  
Laurel Elementary School  
Mariposa Elementary School  
Olinda Elementary School

Department Director: Chris Becerra  
Administrative Assistant: Kayleen Farrer  
Program Technician: JoAnne Warren

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



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 CELL # \_\_\_\_\_ MOTHER'S 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.

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 # \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ARE THERE ANY SPECIAL THINGS YOU WANT US TO KNOW ABOUT YOUR CHILD? (i.e. - fears, eating likes/dislikes, social/emotional difficulties)

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: (If you have no physician, write "School's Choice"). Family Physician: \_\_\_\_\_ Tele # \_\_\_\_\_

What health problems does this student have? \_\_\_\_\_ DATE OF LAST THREE-IN-ONE OR TETANUS BOOSTER \_\_\_\_\_

KNOWN ALLERGIES TO DRUGS: YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE LIST DRUGS: \_\_\_\_\_

POSSIBLE EMERGENCY HEALTH PROBLEMS 1. SEIZURES/EPILEPSY 2. BEE STING ALLERGY 3. DIABETIC 4. SEVERE HEART PROBLEM

5. ASTHMA 6. PHYSICAL PROBLEM (LIMITED PHYSICAL ACTIVITY, ETC.) 7. SEVERE ALLERGY (EXPLAIN) \_\_\_\_\_

8. OTHER (EXPLAIN) \_\_\_\_\_ DOES YOUR CHILD TAKE ANY MEDICATION CONTINUOUSLY: YES \_\_\_\_\_ NO \_\_\_\_\_ IF SO, WHAT AND AMOUNT \_\_\_\_\_

HAS SHE/HE ANY VISION OR HEARING PROBLEMS WHICH WOULD AFFECT HER/HIS SCHOOL WORK? \_\_\_\_\_ ANY OTHER PHYSICAL CONDITION(S) THE SCHOOL SHOULD BE AWARE OF? \_\_\_\_\_

UNIFORMED 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 ENDEAVOR. 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 adults (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

**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 Care Services for pictures of activities for Child Care Services Activities.

Please complete and sign the form below.

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

I give my permission for

\_\_\_\_\_ (child's name)

To have his/her picture taken for

\_\_\_\_\_ Pictures of Activities \_\_\_\_\_

\*I do not give my permission for

\_\_\_\_\_ (child's name)

To have his/her picture taken for

\_\_\_\_\_ Pictures of Activities \_\_\_\_\_

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

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Student Name \_\_\_\_\_

School of Attendance \_\_\_\_\_