



Preschool Student File Checklist

Preschool Student Name: _____ Date of Birth: _____

THE FOLLOWING INFORMATION, which is required under sections of Title 22, California Code of Regulations and/or Statute, MUST BE KEPT IN THE FACILITY, COMPLETE AND CURRENT, AND READILY AVAILABLE FOR REVIEW

Preschool Student Files

	Current Admissions Agreement with Authorized Signature(s)
	PM 286 - California School Immunization Records (Blue Card)
	LIC 613A - Personal Rights - Community Care Facilities
	LIC 627 - Consent for Medical Treatment
	LIC 700 - Identification and Emergency Information - Child Care Centers
	LIC 701 - Child's Preadmission Health Evaluation - Physician's Report
	LIC 702 - Child's Readmission Health History - Parents' Report
	LIC 995 - Signed and dated receipt of Notification of Parents' Right

Available as Needed in Director's Office

	LIC 9166 - Documentation required for health-related services (e.g., nebulizer care)
	LIC 9221 - Authorizations for dispensing medications, signed by each child's authorized representative
	LIC 622 - Centrally Stored Medication and Destruction Record (if Medications handled)
	LIC 624 - Unusual Incident/Injury Report
	LIC 9224 - Acknowledgement of receipt of licensing reports

PERSONAL RIGHTS**Child Care Centers**

See Title 22, Section 101223 of the California Code of Regulations for personal rights applicable to Child Care Centers.

- (a) Each child receiving services from a Child Care Center shall have rights which include the following:
- (1) To be accorded dignity in their personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet their 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 their authorized representative informed, by the licensee of the 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 their choice. Attendance at religious services, either in or outside the facility, shall be voluntary. In Child Care Centers, decisions concerning attendance at religious services shall be made by the child's authorized representative. To the extent that the child's authorized representative has agreed to the child's compulsory attendance at religious services and activities as a condition of admission in the admission agreement, a Child Care Center may require a child's attendance at such religious services and activities.
 - (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

Riverside Regional Office

ADDRESS

3737 Main Street, Suite 700

CITY

Riverside, CA

ZIP CODE

92501

AREA CODE/TELEPHONE NUMBER

(951)7824200

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)

St. Peter the Apostle Catholic School

(PRINT THE ADDRESS OF THE FACILITY)

450 S. Stage Coach Lane, Fallbrook, CA

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

CONSENT FOR EMERGENCY MEDICAL TREATMENT-

Child Care Centers Or Family Child Care Homes

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

St Peter the Apostle Catholic Preschool

FACILITY NAME

 TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH(D.O.) OR DENTIST (D.D.S.) FOR

_____.

NAME THIS CARE MAY BE GIVEN UNDER

WHATEVERCONDITIONS 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
()	()

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	S T A T E	ZIP
BIRTHDATE					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	S T A T E	ZIP
HOME TELEPHONE ()					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	S T A T E	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

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

DATE OF ADMISSION

LAST DATE OF ENROLLMENT

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE 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* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
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PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS?

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF:

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*	
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*	
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST		
	LUNCH		
	DINNER		
WHAT ARE USUAL EATING HOURS?	BREAKFAST		
	LUNCH		
	DINNER		
ANY FOOD DISLIKES?		ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
☐ YES ☐ NO		☐ YES ☐ NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
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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)

Saint Peter the Apostle Catholic School. This Child Care Center/School provides a program which extends from **7:30am to 5:00pm**

(NAME OF CHILD CARE CENTER/SCHOOL)

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 ☐ I have not ☐ reviewed the above information with the parent/guardian.

Physician: _____

Date of Physical Exam: _____

Address: _____

Date This Form Completed: _____

Telephone: _____

Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

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 Riverside Regional Office**

Licensing Office Address: **3737 Main Street, Suite 700, Riverside, CA 92501**

Licensing Office Telephone #: **(951)782-4200**

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.

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