

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/Community Care Licensing Division

ADDRESS

750 The City Drive, Suite 250

CITY

Orange

ZIP CODE

92668

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)

Merage JCC of OC, Early Childhood Learning Center

(PRINT THE ADDRESS OF THE FACILITY)

1 Federation Way, Suite 200, Irvine, CA 92603

(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

_____ 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
()

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					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	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
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**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY
CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	LAST DATE OF ENROLLMENT
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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)

_____. 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: _____ 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'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
<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?*
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?*
<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
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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: Dept. Social Services, Community Care Licensing Division

Licensing Office Address: 750 The City Drive, Ste. 250

Licensing Office Telephone #: Orange, Ca. 92668

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

Authorization for Charges

Child's name _____

EXTRA HOURS

During our normal hours of operation, additional hours can be requested in advance on a periodic, as needed basis, provided we have adequate staffing. The fee for this service is \$30 per hour with a one-hour minimum. Additional time will be calculated in half-hour increments. In order to use this service we require advance authorization to charge your card on file.

Parents who require this service more than three times a month are asked to enroll in a plus-day or full-day program.

Please note: At no time is this service available before or after regular school hours or on days when your child is not enrolled in class.

I authorize the Merage JCC to charge my credit card on file for any extra hours my child may stay at school at the above specified rates.

Parent/guardian signature _____ Date _____

HOT LUNCH

Hot lunch forms are provided at the ECLC front desk. When your child does not bring lunch to school and has not ordered a hot lunch, we will provide your child with lunch at a fee of \$7 per lunch.

We require advance authorization to charge your card on file for this service.

I authorize the Merage JCC to charge my credit card on file for \$7 for each lunch they provide my child if provisions for lunch were not made in advance and they did not have a lunch that day.

Parent/guardian signature _____ Date _____

MEDICAL TREATMENT:

Waiver: PARENTS/Guardians: You are asked to sign this Waiver so that your child may engage in activities of the Jewish Community Center ("JCC"). Any alteration, addition or deletion to this form will nullify this waiver.

The JCC deems these activities to be worthy for children, but, does not require them. These activities are voluntary, and a signed Waiver Form is one of the conditions before participation.

We, the undersigned, parent/s or guardian/s of _____, a minor, do hereby authorize the JCC, its agents and employees, to act as agent/s for the undersigned in the event of any illness, injury or physical complaint of whatever nature or severity, to consent to any medical or surgical diagnosis or treatment and hospital care for said minor which is deemed advisable by any licensed health care provider.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent/s to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned health care provider in the exercise of his/her best judgment may deem advisable, pursuant to the provisions of Section 25.8 of the Civic Code of the State of California.

In consideration of the activities afforded this child by the JCC, I hereby permit said child to participate in Center activities for which she/he is registered. I hereby release the said JCC and its participating members and employees from any liability whatsoever to the undersigned resulting from, or in any manner arising out of any injury or damage which may be sustained by the said child on account of his/her participation in said activities, or in the transportation in connection therewith.

I further agree that, in case any action is brought against the JCC, its participating members or employees, for or on behalf of the aforementioned child or on account of any injury during his/her participation in the above - mentioned activities, I will indemnify them and hold them harmless.

This authorization shall remain effective so long as the undersigned is a participant in the JCC, unless sooner revoked in writing and delivered to said agent/s.

Parent/Guardian Signature _____ Date _____

Health and Safety

ECLC staff reserves the right to determine when a child needs to be picked up from school and when a child can return. I understand and agree to arrange for my child to be picked up within 30 minutes of being informed by an ECLC staff member.

Parent/Guardian Signature _____

IF THERE IS ANYTHING YOU WOULD WANT EMERGENCY ROOM PERSONNEL TO BE AWARE OF (i.e., medicine, allergy), PLEASE NOTE BELOW:

PHOTOGRAPHS:

The Merage JCC may videotape or photograph participants enrolled in our programs. These photographs are for the Merage JCC publications, flyers, publicity efforts, brochures, web use, other electronic communications or video usage. All photos and videos are for Merage JCC use and become the sole property of the Merage JCC. Contact the ECLC office for photographic exclusions for your child(ren).

NUT-SENSITIVE SCHOOL:

Knowing that children share food, and as a courtesy to those children who may have a serious allergy to nuts and nut products, I will not send my child to school with snacks, lunch, or treats containing peanut butter or nuts on the content label.

Parent/Guardian Signature

Does your child have any physical disabilities, limitations, or restrictions? Please explain:

Does your child require any special medication while at the JCC ECLC?

No Yes, please send a medication authorization form to be signed by my child's physician.

Does your child have any history of the following: (if so, please explain)?

Allergies _____
 Asthma _____
 Diabetes _____
 ADD/ADHD _____

Parent Handbook Agreement

Welcome to the Erica and Sheila Samson Family Early Childhood Learning Center

Please sign and return to front desk.

Thank you!

I, _____, parent of _____ (name of child) have read and agreed to abide by the policies and conditions set forth in the preceding parent handbook of the Merage JCC Early Childhood Learning Center.

Signature

Date

Sunscreen Utilization

As the parent of _____

I give I do not give my permission for the staff of the Aronoff Preschool to apply an SPF sunscreen product to my child, as specified below, when he or she will be engaging in outdoor activities.

I understand that sunscreen may be applied to exposed skin, including, but not limited to the face, tops of ears, nose and bare shoulders, arms and legs.

I understand that it is my responsibility to apply sunscreen to my child in the morning before he/she arrives at school. The staff will re-apply sunscreen only when the morning application may have worn off.

I understand that it is my responsibility to purchase sunscreen for my child and bring it to the preschool, labeled with their name.

Choose any that apply:

If I have not provided a sunscreen product, the staff of the Aronoff Preschool may use a sunscreen product of their choice, in keeping with the applicable federal and state standards.

Only use the following type(s) of sunscreen:

For medical reasons, please do not apply sunscreen to the following areas of my child's body _____

This authorization will remain in effect as long as my child is enrolled in the Aronoff Preschool. It is my responsibility to change this form if a change in application or SPF is necessary.

Parent/guardian signature

Date

Aronoff Preschool

Topical Ointment Administration Permission

Child's Name _____

- I understand that this authorization is to be used only for topical creams and ointments such as diaper cream, lotion, and lip balm.
- I understand that medicated creams and over-the-counter creams/ointments such as Desitin, Aquaphor, ButtPaste, Vaseline, A+D, Aveeno, Balmex, etc that have an *active* ingredient are to only be used on the diaper area and/or as a preventative measure.
- I understand that application to open sores, injuries, or continued use on a persistent diaper rash requires a Medication Authorization form signed by my child's physician and is not authorized under the terms of this form.
- I understand that the Aronoff Preschool will not apply topical ointments or lotions to a rash or skin condition. Any topical medication for skin rashes and/or skin conditions (such as eczema, psoriasis, etc.) requires a Medication Authorization form signed by my child's physician and is not authorized under the terms of this form.
- I understand this form authorizes the Aronoff Preschool at the Merage JCC to apply topical ointments only supplied by my child's legal guardian(s). The preschool will not supply ointments or allow use of another child's ointment on my child.
- I understand that the ointment provided must be appropriate for use on a child and will be applied according to the instructions on the label.
- ***I understand the ointment must be labeled with my child's full name and handed to administration and not left in my child's bag or cubby.***
- I understand this authorization will remain in effect as long as my child is enrolled in the Aronoff Preschool. It is my responsibility to withdrawal this authorization should I choose to do so.

Parent/guardian signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF LICENSING REPORTS

I, as the parent/legal guardian of _____, currently attending or newly enrolled at _____ child care center/family child care home acknowledge I have received the following information as required by Health and Safety Code sections 1596.8595 and 1596.8895.

- Copy of any licensing report that documents a Type A deficiency cited at this facility; Type A deficiencies are those that, if not corrected, represent an immediate risk to the health, safety or personal rights of children in care. This includes facility visits and substantiated complaint investigations.

Date(s) of licensing report(s) provided: _____

- Copy of licensing documents pertaining to a conference conducted by a local licensing agency management representative and the licensee of this child care center/family child care home in which issues of noncompliance are discussed.

Date of document provided: 03/04/2024

- Copy of the Accusation Summary indicating the Department's intent to revoke the license of this child care center/family child care home, until that accusation is either dismissed or resolved through the administrative hearing process or stipulated agreement.

Date of document provided: _____

- As a parent/legal guardian of a newly enrolled child in this child care center/family child care home, I have been provided the documents identified above received by the licensee during the 12-month period prior to my child's enrollment.

My signature below verifies I have received the documents identified above.

PARENT/LEGAL GUARDIAN SIGNATURE:	DATE DOCUMENTS RECEIVED:
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Child Background Information



Child's name _____ Preferred name _____

Is this your child's first time in a group care setting? Yes No

Who lives in your home? Please provide names and relationship to child.

Does your child have more than one residence they call home? Yes No

What language(s) are spoken at home?

Have you thought about your drop off routine? What will it look like?

What does your child need to calm down when they are upset?

What is the potty routine at home? Is your child potty proficient? Do they need a Pull-Up for nap?

What familiar words are used for personal hygiene?

Does your child prefer to play alone or with siblings/friends?

What is your child's favorite toys, games or activities?

Are there any specific behaviors/habits/idiosyncrasies we need to be aware of while your child is here at school? Example-child needs to rest after sun exposure, etc.

Please share any major events, if any, that may impact your child's behavior or social-emotional health. Examples: recent move, new baby, divorce, family member passed away, hospitalization of a family member, etc.

Is your child scared of anything in particular? _____
Does your child have any allergies or conditions (ex. asthma) in which we should be aware? If yes, please list them below.

Does your child require medication to be administered while in our care? If yes, please note them below and see preschool front desk staff to complete required paperwork.

Is there anything you want emergency personnel to know about your child? If yes, please write it below.

Have you considered having your child assessed for any concerns (speech, not yet reaching developmental milestones)? Yes No
If yes, briefly describe your concern. Has it been resolved?

Has your child had any formal assessments (OT, Speech, ABA)? Yes No
If yes, briefly describe the assessment and any findings.

Is your child receiving any services? Yes No
If yes, please list services, and how often they occur.

Please add any other information that you would like us to know about your child.

I understand the information provided on this form will be shared with appropriate preschool staff on a "need-know" basis. Initial _____