

# CALVARY CHAPEL OF YORBA LINDA PRESCHOOL



## Application for Enrollment

2020-2021

Date: \_\_\_\_\_ Enrollment to begin: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ [ ] Male [ ] Female

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Father: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If You Attend A Church Please Indicate Name & City: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_ Father's Email Address: \_\_\_\_\_

Check wherever true:

Pupil lives with (*Please attach a copy of custody arrangement if child resides in multiple homes*):

Own Father: \_\_\_\_\_ Stepmother: \_\_\_\_\_ Is Adopted: \_\_\_\_\_

Own Mother: \_\_\_\_\_ Stepfather: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Other: \_\_\_\_\_

Parents are:

Married: \_\_\_\_\_ Remarried: \_\_\_\_\_ Deceased: Mother: \_\_\_\_\_

Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Brothers/Sisters: \_\_\_\_\_ Date of birth: \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

CCYL Schedule:

FULL DAY (6:30am-6:00pm) 3 HR. PROGRAM (8:30am-12:00pm) LUNCH BUNCH (12:00pm-1:00pm)

\_\_\_ 5 days \_\_\_ 5 days \_\_\_ 5 days

\_\_\_ 3 days M/W/F \_\_\_ 3 days M/W/F \_\_\_ 4 days

\_\_\_ 2 days T/ Th \_\_\_ 2 days T/Th \_\_\_ 3 days

\_\_\_ 2 days

Has your child attended preschool previously: \_\_\_ Yes \_\_\_ No

School Name: \_\_\_\_\_ Dates of Enrollment: \_\_\_\_\_

By signing below, we as parents, agree to cooperate with Calvary Chapel of Yorba Linda Preschool and in its program and abide by the policies and tuition payments, acknowledging that tuition is due on the fifteenth of each month and is considered late after the twentieth of each month. After the 20<sup>th</sup> a late fee will be assessed to the account. All previous balances must be made current before re-enrollment. Tuition will be billed monthly.

Signature of Father: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Mother: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use: Date: \_\_\_\_\_ FACTS Enroll date: \_\_\_\_\_

Received by: \_\_\_\_\_ Actual Enrollment Date: \_\_\_\_\_

# CALVARY CHAPEL PRESCHOOL



## TUITION PAYMENT AGREEMENT

September 2020- June 2021

I enroll \_\_\_\_\_ in Calvary Chapel of Yorba Linda Preschool.  
(Student Name)

Check the group in which your child is to be enrolled:

Class	FULL DAY (6:30am-6:00pm)	HALF DAY (8:30am-12:00am)	LUNCH BUNCH (12-1)
<input type="checkbox"/> k-4	<input type="checkbox"/> 5 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 5 days
<input type="checkbox"/> Older Preschool	<input type="checkbox"/> 3 days MWF	<input type="checkbox"/> 3 days MWF	<input type="checkbox"/> 4 days
<input type="checkbox"/> Younger Preschool	<input type="checkbox"/> 2 days T TH	<input type="checkbox"/> 2 days T TH	<input type="checkbox"/> 3 days
<input type="checkbox"/> Toddlers			<input type="checkbox"/> 2 days

Please fill out the following payment schedule using the enclosed Tuition Fee Sheet.

\_\_\_ I agree to pay Annually \$ \_\_\_\_\_ -- \$200 (Annual Pay Discount) = \$ \_\_\_\_\_

\_\_\_ I agree to pay \$ \_\_\_\_\_ per month (minus \_\_\_\_\_) = \$ \_\_\_\_\_  
5% sibling discount

Total Monthly Tuition *including Lunch Bunch (12-1:00)* \_\_\_\_\_

*\*Excludes Toddlers and Younger preschool classes*

This Tuition Payment Agreement is effective as of: \_\_\_\_\_  
(Month/Day/Year)

I agree to pay any late payment charges, returned check charges, overtime charge, or other charges that might be incurred during my child's enrollment. I am aware that tuition is due on the fifteenth of each month and considered late after the twentieth of the month. A late payment fee of \$25 will be assessed after the twentieth day of the month. I understand that if my account becomes 1 month past due my child will be unable to attend school until my account is paid in full. I will give the school two (2) weeks written notice to withdraw from school.

*This Tuition Agreement Supercedes All Previous Agreements*

\_\_\_\_\_  
Signature of Parents or Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Administration Approval

\_\_\_\_\_  
Date Signed

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*For Office Use Only*

Teacher: \_\_\_\_\_

New Student [ ]

*CONTRACTUAL AMENDMENT(S)/COMMENTS*

Start Date: \_\_\_\_\_

Eligible for Vacation: \_\_\_\_\_

Computer Input: \_\_\_\_\_

Copy To: \_\_\_\_\_

## PRESCHOOL ENROLLMENT PACKET INSTRUCTIONS

Dear Parents,

Thank you for choosing Calvary Chapel of Yorba Linda Preschool as the place to enroll your child. Enclosed you will find the forms that are needed to complete your child's Student File. This packet must be returned to the school AT LEAST 3 DAYS BEFORE YOUR CHILD'S FIRST DAY of school. (Please use this list as a checklist to make sure that all of the forms are in the file when you return it to the school.)

\_\_\_\_\_ Application for Enrollment - Fill out completely and return.

\_\_\_\_\_ Tuition Payment Agreement - Fill out completely and return

\_\_\_\_\_ Identification and Emergency Information - Fill out completely and return

\_\_\_\_\_ Parent's Rights Form - Must be signed by the parent.

\_\_\_\_\_ Personal Rights Form - Must be signed by the parent..

\_\_\_\_\_ Important Information for Parents Caregiver Background Check Process

\_\_\_\_\_ Consent for Medical Treatment - Fill out completely and return.

\_\_\_\_\_ Placentia-Linda Consent to Treatment - Emergency cases are taken to Placentia-Linda Hospital and this Consent to Treatment must be on file.

\_\_\_\_\_ Child's Pre-Admission Health History Report (Parent's) - Complete this form noting any significant medical problems that the child has had in the past and daily health routines.

\_\_\_\_\_ Physicians' Report - Must be completed by your child's physician and returned to school.

\_\_\_\_\_ Consent For Tylenol or Motrin Treatment

\_\_\_\_\_ Admission Agreement - Fill out completely and return.

\_\_\_\_\_ Preschool Directory/Student Allergy Posting - Fill out completely and return.

\_\_\_\_\_ Toddler Admission Agreement (If Applicable) - Fill out completely and return.

\_\_\_\_\_ Media Release form- Fill out completely, Sign and return.

\_\_\_\_\_ Birth Certificate - Return a copy of child's birth certificate.

\_\_\_\_\_ Insurance Plan - Make a copy of insurance card.

\_\_\_\_\_ California Immunization Record - All students entering school must have an updated P immunization record and TB test.

Please be informed that all of these forms must be turned into the Preschool Office prior to your child's first day. If you have questions regarding this packet, please feel free to call the Preschool Office - (714) 777-7131.

Thank You!

**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
FATHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
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 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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# 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 WHATEVER  
NAME  
CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED  
ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

X \_\_\_\_\_  
DATE

X \_\_\_\_\_  
PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

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

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# Placentia Linda Hospital

## AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(714) 993-2000

(I) (We), the undersigned parent(s) of \_\_\_\_\_ a minor, do hereby authorize Placentia Linda Hospital as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of Placentia Linda Hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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 all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until \_\_\_\_\_, 19\_\_\_\_, unless sooner revoked in writing delivered to said agent(s).

(I) (We) hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

DATE: \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

Other contact in emergency \_\_\_\_\_

Phone Number \_\_\_\_\_

495

Signature of Father or legal guardian \_\_\_\_\_

Signature of Mother or legal guardian \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone or Message Phone \_\_\_\_\_

PL0820/152051

### FOR PATIENT'S PROTECTION PLEASE COMPLETE

1. ALLERGIES AND SENSITIVITIES: Is there a history of skin or other untoward reaction or sickness following injection or oral administration of:

	CIRCLE ONE		WHAT
(a) Penicillin or other antibiotics	yes	no	_____
(b) Morphine, Codeine, Demerol or other narcotics	yes	no	_____
(c) Novacaine or other anesthetics	yes	no	_____
(d) Aspirin, Empirin or other pain remedies	yes	no	_____
(e) Sulfa Drugs	yes	no	_____
(f) Tetanus antitoxin or other serums	yes	no	_____
(g) Adhesive tape	yes	no	_____
(h) Iodine or merthiolate	yes	no	_____
(i) Any other drug or medication	yes	no	_____
(j) Any food, such as egg, milk or chocolate	yes	no	_____

2. DRUGS TAKEN RECENTLY: Within the past six (6) months has the patient taken:

(a) Cortisone	yes	no	_____
(b) ACTH	yes	no	_____
(c) Anticoagulants	yes	no	_____
(d) Tranquilizers	yes	no	_____
(e) Hypotensives (high blood pressure medicines)	yes	no	_____

3. Has the patient ever received treatment for Asthma, Rheumatism or Rheumatic Fever? yes no

4. Birthday: \_\_\_\_\_ Date of last Tetanus or DPT shot: \_\_\_\_\_

Source of information, if other than patient: \_\_\_\_\_

\_\_\_\_\_, M.D.

Family Doctor of Pediatrician

# CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER 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"/> Asthma		<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps	
		<input type="checkbox"/> Poliomyelitis	
		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
		<input type="checkbox"/> Three-Day Measles (Rubella)	

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?)		WHAT ARE USUAL EATING HOURS?
BREAKFAST _____		BREAKFAST _____
LUNCH _____		LUNCH _____
DINNER _____		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
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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: \_\_\_\_\_  
other: \_\_\_\_\_

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: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_  
Date This Form Completed: \_\_\_\_\_  
Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

# CONSENT FOR TREATMENT WITH 'TYLENOL' OR 'MOTRIN'

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AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I  
HEREBY GIVE CONSENT TO CALVARY CHAPEL PRE-SCHOOL TO ADMINISTER  
'TYLENOL' OR 'MOTRIN' TO: \_\_\_\_\_

THIS TREATMENT MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE DEEMED  
NECESSARY TO BRING DOWN A FEVER.

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CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Agency Representative/Guardian Signature

\_\_\_\_\_  
HOME ADDRESS

\_\_\_\_\_  
HOME PHONE

( )

\_\_\_\_\_  
WORK PHONE

( )

\_\_\_\_\_  
COMMENTS:

### CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS



**FILE COPY**

#### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

*Gave to Parents*

1. Enter and inspect the child care center without advance notice whenever children are in care. *CB*
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 Dr. Suite 250, Orange

Licensing Office Telephone #:

(714) 703-2818

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](http://www.meganslaw.ca.gov)*

LIC 995 (12/06)

(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.

Calvary Chapel Yorba Linda

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](http://www.meganslaw.ca.gov)*

LIC 995 (12/06)

**COPY FILE**  
gave to parent sm

## 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) 703-2818

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) Calvary Chapel Yorba Linda	(PRINT THE ADDRESS OF THE FACILITY) 5401 Fairmont Blvd. Yorba Linda CA, 92886
(PRINT THE NAME OF THE CHILD)	
(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	
(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

## 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



**FILE COPY**

Gave copy to  
parents CB

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\\_1829.htm](http://ccl.dss.cahwnet.gov/RegionalOf_1829.htm)

## Preschool Directory

Please check the appropriate box below to indicate if you would, or would not, like to be included in our Preschool Directory

Yes, list me in your Preschool Directory

No, I do not wish to be listed in your Preschool Directory

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(Parent/ Guardian Full Name)

Date

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## Student Allergy Posting

In order to ensure that all teachers are aware of student allergies, we will post a student allergy list in each classroom. Please indicate whether or not your child has any allergies.

No, my child does not have any known allergies.

Yes, my child \_\_\_\_\_ has the following allergies: \_\_\_\_\_

and these allergies may be posted in order to notify all staff at Calvary Chapel Yorba Linda Preschool.

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(Parent/ Guardian Signature)

Date

## ADMISSION AGREEMENT

An "Admission Agreement" is a signed statement saying that the parent, by reading the Parent's Handbook, is informed about the basic services, available optional services, payment provisions including basic rates, optional service rates, due rates, and frequency of payments, conditions under which the enrollment may be terminated, your child's personal rights, and your rights as a parent.

On signing the "Agreement", the parents give the Department of Social Services, the licensing agency, the authority to interview children or staff, and to inspect and audit the child or facility records without prior consent. The Department of Social Services, the licensing agency, shall have the authority to observe the physical condition of the child/children, including conditions which could indicate abuse, neglect, or inappropriate placement.

The Calvary Chapel of Yorba Linda Preschool shall make provisions for private interviews with any child/children, or any staff member; and for the examination of all records relating to the operation of the facility.

I have read the Parent-Student Handbook and understand and agree to all the Calvary Chapel Yorba Linda Preschool Policies and Procedures, and will, to the best of my ability, abide by them.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**\*Please give this page to the Administrator upon Enrollment**

\_\_\_\_\_  
Administration Office

\_\_\_\_\_  
Date Received

## Calvary Chapel Yorba Linda Preschool Media Release Form

Throughout the school year there may be times when your child will be photographed or videotaped at school events for school purposes. Any photos or videos will be used *for school purposes only*. Please check the appropriate box for your consent regarding your child.

- I do hereby permit Calvary Chapel Yorba Linda Preschool to use in whole or part photographs, videos, art, or written extractions of my child for the purpose of classroom display, school functions, and the school website (*your child's name will not be published on the website*).
- I do hereby permit Calvary Chapel Yorba Linda Preschool to use in whole or part photographs, videos, art, or written extractions of my child for the purpose of classroom display, and school functions only.

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

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_