Shepherd of the Valley

Lutheran Preschool and Kindergarten

11650 Perris Boulevard
Moreno Valley, CA 92557

School (951) 924-3422
Church (951) 924-4688

Dear Family,

Welcome to Shepherd of the Valley Lutheran School. We are planning an exciting, educational year for your child. Please take the time now to fill out all of the necessary forms for your child to enroll in Preschool / Kindergarten. As you complete a form, check it off of the list below. This will help you keep track of what needs to be done. When you complete all of the forms, please return the packet as soon as possible to the Director. This will get information to the teacher as soon as possible so (s)he can include your child in class plans. If any forms are missing from your packet, please contact the Director. Student will not be allowed to attend without a completed file on record.

Thank you and God's blessings,
Shepherd of the Valley Lutheran School

___ Identification and Emergency Form
___ Physician's Report (signed by physician)
___ Pre-admission History
___ Medical Consent
___ Immunization Record *
___ Parent's Rights
___ Personal Rights
___ Acknowledgement of Licensing Report (if applicable)

___ Application for Admission
___ Admission Agreement
___ General Permission
___ Parent Handbook Stub
___ Emergency Card-3 (fill out identically)
___ Prepared Bags (3) Earthquake etc

** **Kindergarten only**

___ Birth Certificate **
___ Dental Form **

* Bring original to be copied

Comments: _____

_____

_____

_____

_____

+ *Linda Williamson, Director* +

Shepherd of the Valley Learning Center

Preschool & Kindergarten

Facility # 330907996

11650 Perris Blvd School 951.924.3422
Moreno Valley, CA 92557 Church 951.924.4688

Application for Admission

Date: _____ Child's Full Name: _____ Child's Date of Birth: _____
First Middle Last

Church Affiliation: _____ Baptized: _____
Yes or No

Brothers: _____
(Names & Ages)

Sisters: _____
(Names & Ages)

Date child will begin school: _____

Preschool: Please circle program and day options:

Half-day (8:15am – 12:15) or Full-day (6:30am-6:00pm) Days: M T W Th F

Kindergarten: Before school care_____ After School Care_____

Parents:

Name of Mother: _____ Age: _____
First Middle Last

Home Address: _____ Home Phone:_____ Cell:_____

City: _____ Zip Code: _____

Place of Employment: _____ Position: _____

Work Phone: _____ Work Hours: _____

Name of Father: _____ Age: _____
First Middle Last

Home Address: _____ Home Phone:_____ Cell:_____

City: _____ Zip Code: _____

Place of Employment: _____ Position: _____

Work Phone: _____ Work Hours: _____

Parent's Marital Status: Married_____ Divorced_____ Single_____ Widowed_____

Email Address: _____

Email Address: _____

How did you hear about our school? Friend/Neighbor_____ Internet_____ Phonebook_____ Other_____

*Enrollment fees are non-refundable Parent Signature: _____

Yearly Registration $110_____ Annual Book/Supply Fee $140_____ Pmt: Amount: _____

Early Registration $55 _____ Summer Only $25 _____ Check# _____

POS _____

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General Permission Slip

Please initial each item and sign at the bottom.

_____ I hereby grant permission for my child to use all of the play equipment and participate in all of the activities at the school.

_____ I hereby grant permission for my child to be evaluated.

_____ I hereby grant permission for my child to be included in pictures connected with the school program.

_____ I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact child's physician.
3. Attempt to contact you through any of the persons listed on the emergency form that you completed for us.
4. If we cannot contact you or your child's physician another physician or paramedics, (b) call an ambulance, (c) have the child taken to the emergency room of the hospital in the company of a staff member.
5. Any expenses incurred under #4, above will be the responsibility of the child's family.
6. The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
7. The school will not assume responsibility for a child who has not been signed in when she/he arrives for the day.

Signed: _____ Date_____
(Mother or legal guardian)

Signed: _____ Date_____
(Father or legal guardian)

Shepherd of the Valley

Lutheran Preschool and Kindergarten

Linda Williamson, Director

11650 Perris Boulevard
Moreno Valley, CA 92557

School (951) 924-3422
Church 924-4688

Application for Kindergarten Admission

Date _____ Child's Full Name _____

Child's Birth Date _____ Church Affiliation _____

Baptized _____
(Yes or No)

Brothers _____
(Names and ages)

Sisters _____
(Names and ages)

Date child will begin Kindergarten _____

Before School Care _____ After School Care _____

****

Parents:

Name of Mother _____ Age _____
Last First Middle

Home Address _____ Phone _____

City _____ Zip Code _____

Place of Employment _____ Position _____

Work Telephone # _____ Work Hours _____

Name of Father _____ Age _____
Last First Middle

Home Address _____ Phone _____

City _____ Zip Code _____

Place of Employment _____ Position _____

Work Telephone # _____ Work Hours _____

Parent's Marital Status: Married _____ Divorced _____ Single _____

Email address: _____

* Enrollment fees are non-refundable Parent Signature: _____

*** Child must be 5 yr by Sept. 1,** 2020

Parents,

PLEASE READ AND SIGN THIS AGREEMENT.

I understand the following:

1. Kindergarten hours are from 8:00am to 2:00 pm. Children must be picked up by 2:15pm unless my child is enrolled in the after school program.
2. Prior to the first day of attending school, all children must have the registration packet completed and turned into the office.

   This packet includes:

Application for Admission	Admission Agreement
Emergency Cards (3)	General Permission Slip
Immunization Card (up dated)	Physician's Report (signed by the Physician)
Preadmission Health History	Consent for Medical Treatment
Parent's Rights	Identification & Emergency Information
Personal Rights	Parent Handbook Stub
Oral Health Waiver	Copy of Birth Certificate
In Gallon Size Bags:	Earthquake Food Bag (to be stored in a central location)
	Change of clothes for the classroom

3. Tuition Payment Policy:

   Kindergarten Tuition is a flat yearly rate which must be paid in full by May 5th.

   (See the front for Payment Schedule)

   The following methods of payment are accepted:

   Auto Pay Program

   Payments can be automatically taken from your checking, savings, or credit card accounts. (See the Director for forms)

   POS payment

   Swipe your ATM/Credit card for a payment

   Check or Money Order

   Make them out to: Shepherd of the Valley School or SVLS

   Cash

Parent Signature: _____ Date: _____

EMERGENCY CARD

ıild's Name: _____ Birth Date: _____

ldress: _____ Zip _____

›me Phone: _____ Parents Name: _____

›ther's Occupation: _____ Work # _____

ther's Occupation: _____ Work # _____

the event of an emergency and parents can't be reached call:

›ctor: _____ Phone # _____

st any allergies your child has: _____

›me Church: _____ Pastor: _____

I authorize these people to pick up my child (*):

Father: _____

Signature: _____

Mother: _____

Signature: _____

1. _____ Phone # _____

Signature: _____

2. _____ Phone # _____

Signature: _____

3. _____ Phone # _____

Signature: _____

(*) List at least three besides parents.

EMERGENCY CARD

Child's Name: _____ Birth Date: ___

Address: _____ Zip _____

Home Phone: _____ Parents Name: _____

Mother's Occupation: _____ Work # _____

Father's Occupation: _____ Work # _____

In the event of an emergency and parents can't be reached call:

Doctor: _____ Phone # _____

List any allergies your child has: _____

Home Church: _____ Pastor: _____

I authorize these people to pick up my child (*):

Father: _____

Signature: _____

Mother: _____

Signature: _____

1. _____ Phone # _____

Signature: _____

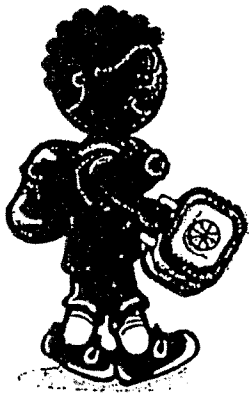
2. _____ Phone # _____

Signature: _____

3. _____ Phone # _____

Signature: _____

(*) List at least three besides parents.



Earthquake Kit

Child's Name _____

____ Change of Clothes

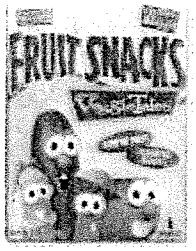
____ Under Pants (one change)

____ Socks (one Pair)

____ Family Picture

____ Special |Message From Family

____ Small Toy



EARTHQUAKE FOOD BAG

Name:

You will need to place non-perishable food items in this gallon size zip-lock bag, including drinks. You may want to include a family photo or a special note for your child.

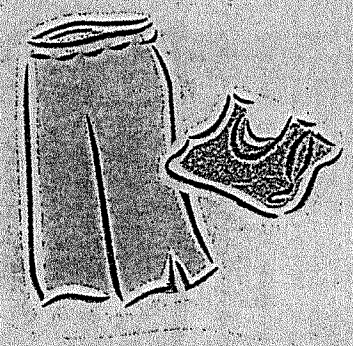
Please note: In an emergency situation we will not be able to cook, so supply foods that can be eaten cold.

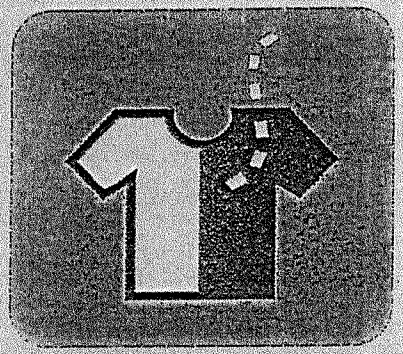
Example:

Individual size:

- Vienna Sausages
- Pork and Beans
- Nuts, Dried Fruit, Pretzel Pack
- Crackers and Cheese Packs
- Fruit Snacks
- Box or Bag Drinks

Please put enough for two small meals for your child and try and find foods that they enjoy.





Change of Clothes for

Child's Name: _____

Include these needed items:

- A Shirt
- A pair of pants
- A pair of socks
- Two pair of underwear

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
☐ 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?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S 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'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

Oral Health Assessment/Waiver Request Form

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment by May 31 in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

Section 1

To be completed by the parent or guardian

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Gender: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ American Indian □ Alaska Native □ Native Hawaiian/Pacific Islander □ Multi-racial □ Unknown		

Section 2

Oral Health Data Collection

To be completed by the dental professional conducting the assessment

Assessment Date:	Visible caries and/or fillings present: □ Yes □ No	Visible caries present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended □ Urgent care needed

Dental professional's signature *Date*

Section 3
Waiver of Oral Health Assessment Requirement

To be completed by a parent or guardian requesting to be excused from this requirement

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

☐ I am unable to find a dental office that will take my child's insurance plan.
My child is covered by the following insurance plan:
☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ None
☐ Other _____

☐ I cannot afford an oral health assessment for my child.

☐ I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment:_____
_____
_____
_____

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

_____

Signature of parent or guardian *Date*

Return this form to the school by

Original to be retained in child's school record

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Service
Children's Medical Services Branc
Child Health and Disability Prevention (CHDP) Progra

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTHDATE—Month/Day/Year

ADDRESS—Number/Street	City	ZIP Code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE
Health History	
Physical Examination	
Dental Assessment	
Nutritional Assessment	
Developmental Assessment	
Vision Screening	
Audiometric (hearing) Screening	
Tuberculin Test (Mantoux/PPD)	
Blood Test (for anemia)	
Urine Test	
Blood Lead Test	
Other	

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) **(Required for child care/preschool only)**					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

I give permission for the health examiner to share the additional information about the health check-u with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

➤ _____ _____
Signature of parent or guardian — Date

Name, address, and telephone number of health examiner

➤ _____ _____
Signature of health examiner — Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

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 / Inland Empire Child Care

ADDRESS

3737 Main St, Suite 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside	92501	(951) 782-4200

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)
Shepherd of the Valley	11650 Perris Blvd, Moreno Valley, CA 92557

(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

Shepherd of the Valley School
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 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

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

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

DATE OF ADMISSION	DATE LEFT

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/Inland Empire Child Care

   Licensing Office Address: 3737 Main St, 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.

Shepherd of the Valley
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

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

dent Name _____ Sex: M ☐ F ☐ Birthdate _____ Place of Birth _____

me of Parent or Guardian _____ Address _____

ephone _____ City _____ ZIP _____
Daytime Nighttime

Race/Ethnicity:
- ☐ White, not Hispanic
- ☐ Hispanic
- ☐ Black
- ☐ Other: _____

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: _____ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date _____

Staff Signature _____

Record Presented was:
- ☐ Yellow California Immunization Record
- ☐ Out-of-state school record
- ☐ Other immunization record

Specify: _____

II. STATUS OF REQUIREMENTS

- ☐ A. All Requirements are met.
  Date ____/____/____
- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
- ☐ C. Medical Reasons—Permanent
- ☐ D. Medical Reasons—Temporary
- ☐ E. Personal Beliefs

III. 7th GRADE ENTRY

- ☐ A. All Requirements are met.

Name _____ Date _____

- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Name _____ Date _____

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
   A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
   B. If the child has met all immunization requirements, check box A and write in date.
   C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
   D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
   E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la comunidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) _____ Date (Fecha) _____

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____ Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.