

# Summer Bees Enrollment Forms

Ages 2-4 &  
Potty Trained,  
Pull-ups are OK



Enroll at  
[www.CalElite.com](http://www.CalElite.com)

# Summer Bees

Cal Elite Kids  
(License 304370485)



# Enrollment Checklist - REQUIRED before starting

## Cal Elite Forms

- Paperwork Checklist
- Student Application
- Sign In/Sign Out Policy
- Late Pick Up Policy/Early Drop Off Policy
- Sick Policy
- Please tell us about your child



## State Forms

- LIC 700 Identification and Emergency Information
- LIC 702 Child Preadmission Health History
- LIC 995 E (review and keep for your records)
- LIC 995 Child Care Center Notification of Parents' Rights: Please detach the form along the perforated line. Keep the top portion for your records and return the bottom portion, signed, with your completed packet.
- LIC 613A Personal Rights: Please detach the form along the perforated line. Keep the top portion for your records and return the bottom portion, signed, with your completed packet.
- LIC 627 Consent for Emergency Medical Treatment
- LIC 9221: Students who need medicine administered during school hours must provide written consent for Cal Elite to administer medicine through LIC 9221. This form is needed only if a student needs medicine administered during school hours.
- LIC 701 Physician's Report: Part A is completed by parent/guardian and Part B must be completed by a physician. Students are required to be current with shots unless there is a medical exemption, cleared through a written statement by your doctor.
- Copy of Immunization Records
  - 3 Polio (OPV or IPV)
  - 4 DTaP
  - 3 Hep. B
  - 1 Varicella
  - 1 HIB (must be after 1st birthday regardless of previous HIBs)
  - 1 MMR (must be after 1st birthday)

Questions? Contact Summer Bees Director Kennah Ledford at [Kledford@calelite.com](mailto:Kledford@calelite.com)

# Student Application - Cal Elite Summer Bees



## Student Information

### Preferred Start Date \_\_\_\_\_

First choice

Second choice

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

## Parent/Guardian Information

\_\_\_\_\_  
Legal Gaurdian Name

\_\_\_\_\_  
Cell

\_\_\_\_\_  
Email

\_\_\_\_\_  
Address if Different from Student's

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Other Legal Guardian Name

\_\_\_\_\_  
Cell

\_\_\_\_\_  
Email

\_\_\_\_\_  
Address if Different from Student's

\_\_\_\_\_  
Occupation

## Student Health History

Please describe any MEDICAL concerns that might affect your child's daily activities or prevent him/her from participating in Cal Elite's active learning Summer Bees program.

\_\_\_\_\_  
Please describe any BEHAVIORAL OR SOCIAL concerns that might affect your child's daily activities or prevent him/her from safely interacting with students and teachers.

## How did you hear about us?

Instagram     Facebook     Newspaper/flyer/catalog     Search engine (Google, Yahoo. etc.)     Friend/referral

Other, please explain

\_\_\_\_\_  
Parent/Guardian's Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Sign In/Sign Out Policy



The State of California requires that licensed child care centers have a written policy reflecting that parents must properly sign their child in and out each day. Pursuant to this mandate and in an effort to maintain practices that promote the safety and well being of our students, Cal Elite has implemented the following Sign In/Sign Out Policy:

I/We understand that the Child Care Licensing Division of the California Department of Social Services requires licensed child care centers to obtain the full signatures of parents when dropping their child off (sign in) and when picking their child up (sign out.)

I/We agree that I/We will sign my/our child in and out each day s/he attends school, using my/our full legal signature.

I/We also understand and agree that Cal Elite Kids will not release my child to anyone who is not on the Authorized Pick Up List and that anyone so authorized by me to pick up my child will be required to show a valid photo I.D. The Cal Elite Staff member overseeing drop off and pick up must also sign next to the Authorized Pick Up person's signature.

---

Parent/Guardian Name (print)

Parent/Guardian Signature

Date

---

Cal Elite Staff Name (print)

Cal Elite Staff Signature

Date

Questions? Contact Director Kennah Ledford at [kledford@calelite.com](mailto:kledford@calelite.com)

## Late Pick Up Policy



We appreciate those parents who consistently pick up their child on time. When a child is not picked up on time, our business and educational operations are compromised. Unfortunately, after years of resisting, we have found it necessary to impose a Late Pick Up Policy.

When a child is not picked up on time we are forced to hold a teacher over to cover state mandated student-teacher ratios. The California Labor Code requires that employees be given a 30 minute lunch break. When students are not picked up on time, a teacher's lunch break is delayed and another teacher must cover for that teacher. This affects our student-teaching ratios and causes teachers to go into overtime. In addition, our teachers have their own personal obligations after work. When a child is picked up late our teachers are late to appointments, meetings and picking up their own children after school.

**A late fee of \$1 per minute will be assessed when a child is not picked up on time. The late fee begins promptly at 11:31 a.m. This fee will show up on the next billing statement.**

---

Parent/Guardian Name (print)

Parent/Guardian Signature

Date

---

Cal Elite Staff Name (print)

Cal Elite Staff Signature

Date

## Early Drop Off Policy



Students may not be dropped off before their scheduled drop off time. Summer Bees begins at 9:30 a.m. Students may not enter the classroom until they are welcomed in by the teachers at 9:30 a.m.. We appreciate that parents and siblings stay outside of the classroom so that our Summer Bees schedule is not interrupted.

Thank you for helping us to ensure that students are properly supervised at all times and that we are able to meet our student-teacher ratios at all times.

---

Parent/Guardian Name (print)

Parent/Guardian Signature

Date

---

Cal Elite Staff Name (print)

Cal Elite Staff Signature

Date

Questions? Contact Director Kennah Ledford at [kledford@calelite.com](mailto:kledford@calelite.com)



# Cal Elite Sick Policy

## General Protocol

Per California state licensing, a child who becomes ill with the following symptoms cannot return to school until the symptoms have been resolved for at least 24 hours.

- Green mucus
- Cold symptoms such as cough, stuffy/runny nose, sneeze
- Sore throat
- Diarrhea
- Vomit
- Low grade fever (99.5 and above)
- Fever
- Ear or eye irritation, including red discoloration, excessive drainage or discharge
- Rash or spots/bumps, especially with a fever or itching
- Lice
- Unusually tired, pale, lack of appetite, confused or cranky
- Difficulty breathing or untreated asthma

Thank you for your cooperation. It is imperative that we work together to stay well.

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

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

Questions? Contact Summer Bees Director Kennah Ledford at [kledford@calelite.com](mailto:kledford@calelite.com)

# Please tell us about your child.



1. What are some of your child's favorite things to do?
  
2. What are a few special talents that your child has?
  
3. Does your child have a favorite character - from a book, movie, show or cartoon?
  
4. How many hours does your child sleep per night, on average?
  
5. Is there anything your child is afraid of?
  
6. What is something that is challenging or frustrating for your child?
  
7. Would you say that your child is more of an introvert or extrovert?
  
8. With respect to relationships with friends and teachers, would you say that your child is resilient, somewhat sensitive or ultra sensitive? Please explain.
  
9. Has your child participated in a formal preschool setting before? \_\_\_\_\_ Childcare setting? \_\_\_\_\_ If so, how would you describe that experience for your child?
  
10. What are your main goals and hopes for your child during his/her time in our Summer Bees program?

## 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

**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
----------------------------	-----------------------------------	---

**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		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
--	------------------------	---

**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 / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> 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

---

# 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 or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, 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

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://cclid.ca.gov/contact.htm>.

## 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: \_\_\_\_\_

Licensing Office Address: \_\_\_\_\_

Licensing Office Telephone #: \_\_\_\_\_

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)*

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

**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

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

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)

(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  
( )

## PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

**NOTE:** Regulation Section 101221 requires the following information be on file.

Child Care Center Name:	License Number:	Date:
-------------------------	-----------------	-------

### PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

Child's Name:	Date Of Birth:
Medication Name:	Dosage:

**I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:**

From \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_ daily while in attendance.  
                     Beginning Date                      Ending Date                      Time of Day

Parent's Signature:	Date:
---------------------	-------

### **MEDICATION CHART** **Staff Documentation of Medication Administration**

Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:

**Upon completion, return medicine to parent or destroy, and place form in child's record.**

Staff:	Date:
--------	-------

# 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: \_\_\_\_\_

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

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

Date of Physical Exam: \_\_\_\_\_

Date This Form Completed: \_\_\_\_\_

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.