Emergency Card

Child's Name _____ **Birth Date**_____
Address _____ **City**_____ **Zip**_____
Mother's Name _____ **Father's Name** _____
Mom's Home # _____ **Father's Home#**_____
Mom's Work# _____ **Father's Work#** _____
Cell#_____ **Cell#**_____
If we are unable to contact parents in an emergency, contact:
Name _____**Phone**_____ **Relation**_____
Child's Doctor_____ **Phone** _____
Allergies: _____
Home Church #_____ **Pastor's Name**_____
Names of persons authorized to pick up child:

1._____ **Phone #**_____
2._____ **Phone #**_____
3._____ **Phone #**_____
4._____ **Phone #**_____

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:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
( )

WORK PHONE
( )

Shepherd Center

15215 E. Janine Dr. Whittier, Ca 90605

Dear Parent

Thank you so much for choosing our school. We would like you to bring the following items on your child's first day of school. Thank you!

Napping Items: (Day Care Students)

All items labeled with child's first and last name

* Small Blanket
* Crib Sheet
* Small Pillow (optional)

Extra Clothes:

All items labeled with child's first and last name

* Shirt
* Pants or shorts
* Socks
* Underwear
* Diapers and wipes for non-potty trained

Breakfast;

* Children can bring Breakfast to eat here at Shepherd
* Children can only eat breakfast between the hours of-6:30-8:00
* Every classroom has a microwave, we can warm up their breakfast if needed

Lunch:

* Each child needs to bring his or her own Lunch each day
* Please mark the lunch box or lunch bag clearly with your child's name
* Please refrain from sending junk food
* Every classroom has a microwave, we can warm their lunch if needed
* No T.V. Dinners
* Ice pack, if it needs to be refrigerated

Other Important Items:

* Complete Enrollment package, Registration Fee, Tuition & Immunization Card
* And lot's of Kisses and Hug's for your child's first day!!!!!

Welcome!

Shepherd Center Preschool

(562) 693-8969

Days	Day Care (6:30 am - 6:00 pm)		Preschool (9:00 am - 12:00 pm)		
	*p/t	*n/p	*p/t	*n/p	
5	$645	$665	5 $540	$560	Before/After
3	$470	$495	3 $348	$368	School Care
2	$370	$395	2 $305	$320	$10.50 per hour

Extra Day Charge $60.00 Extra Day Charge $50.00

These prices are per month.

We require a registration fee of $140 and $95 material fee for each NEW student, and a $140 annual renewal fee and $95 material fee for CONTINUING students.

(due with August tuition)

Tuition, registration and material fees are non-refundable upon termination.

* n/p non-potty trained * p/t potty trained

Registration Form

Today's date _____ E-Mail _____

Child's Name _____ Birthdate _____

Parent's Name _____ Day Phone _____

Home Address _____ City _____ Zip _____

Home Church _____

Is your child potty trained? Yes _____ No _____

My child will begin at Shepherd Center _____ (start date)

My child is allergic to _____

Circle one: My child will attend **PRESCHOOL** or **DAY CARE**

Circle days: ***Monday*** ***Tuesday*** ***Wednesday*** ***Thursday*** ***Friday***

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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 NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

MOTHER'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 OR AUTHORIZED REPRESENTATIVE | DATE

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

DATE OF ADMISSION | DATE LEFT

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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* 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
☐ 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

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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: Department of Social Services Community Care Licensing Division

   Licensing Office Address: Los Angeles Child Care East 1000 Corporate Center Dr., Ste 200-B

   Licensing Office Telephone #: Monterey Park, CA 91754

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.

LIC 995 (8/02)

(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.

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: ~~Los Angeles Child Care East~~ 1000 Corporate Center Dr., Ste 200-B

CITY: Monterey Park, CA 91754 | 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)

Shepherd Center
Handbook Amendment
Fundraising Policy

Shepherd center is a non-profit school. We strive to keep our tuition at an affordable rate to accommodate all families. We do provide the teachers pay increases as well as offer them medical benefits. Therefore we find it necessary to do fundraisers each school year. The money that is made from our fund raising efforts is always put back into our program either to purchase new items for our classrooms or playground. We rely on 100% parent participation in at least two fundraising events per school year with a minimum of fifty dollars per order or participate in two eight hour work days. If you cannot or do not wish to participate in these opportunities then you have the option to pay a fifty dollar donation two times per school year. These payments can be made at time of enrollment or are due at the time of our winter and spring fundraising events.

By signing below you agree to either participate in our fundraisers or use the alternate giving program of $100.00 as a term of accepting our enrollment conditions.

(Cut and Return lower portion.)

I have read and understand that by enrolling my child at Shepherd Center School I agree to participate in at least two fundraising events to total $100.00 in sales or participate in two eight hour work days. If I choose not to participate in neither, I will donate two payments of $50.00 each due at the time of their winter and spring fundraising events.

Parent Signature_____ Date_____

SHEPHERD PRESCHOOL

MANDATED STATEMENT AKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED CHILD ABUSE

Section 11166 of Penal Code Requires any child care custodian. Medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom her or she knows or reasonably suspects has been the victim of child abuse, or as soon as practically possible, by telephone and to prepare a written report thereof within 36 hours or receiving the information concerning the incident.

"Child Care Custodian" includes teachers, licensed day workers. Administration of community care facilities licensed to care for children, foster parents and group home personnel.

I, _____ parent or guardian of _____,
Have read and understand the requirements of Penal Code Section 11166 as outlined and understand that employees of this facility are mandated by this requirement and will comply with these provisions.

Signature_____ Date _____

SHEPHERD CENTER

PRESCHOOL PHOTO RELEASE FORM

I, _____, the parent of a child/children at _____ (Hereinafter known as the Shepherd Center), agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at the Daycare during normal daycare hours, field trips, or activities. I understand that these photographs may be used either in print or on the Internet for school use only.

The child(ren) are known as: _____.

With my signature below I grant permission for my child(ren) to be photographed, or their images recorded for print or on the Internet for school use only. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

Parent/Guardian Signature _____ Date _____

Relationship to Child _____

Parents we have created an Instagram Account to post our special events that take place throughout the school year! We are very excited about this and hope you all feel the same way, be if you don't, we respect your wishes. Please fill out and return as soon as possible! Thank you so much!

Instagram @shepherd_center_preschool

HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter

SHEPHERD CENTER (NAME OF CHILD CARE CENTER/SCHOOL) This Child Care Center/School provides a program which extends from ___ : ___

a.m./p.m. to _____ a.m./p.m., _____ days a week

15215 E. JANINE DR.
WHITTIER, CA 90605

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:

Vision:

Developmental:

Language/Speech:

Other (Include behavioral concerns):

Comments/Explanations:

Allergies: medicine:

insect stings:

food:

asthma:

other:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND (ACELLULAR) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ 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 Practioner

LIC 701 (B/01) (Confidential)