

DPNS FINAL REGISTRATION CHECKLIST— NURSERY SCHOOL SESSIONS

Please make sure that all required documents are sent to your Session Registrar by July 15th for enrollment the following fall.

✓ indicates that this form is required annually.

| FORM | New Family Alumni Family Playgroup Grad | Continuing Family, New Student <small>(sibling enrolled previous year)</small> | Continuing Student |
|---|---|--|---|
| INITIAL ENROLLMENT FORMS Due June 1 | | | |
| Admission Agreement | ✓ | ✓ | ✓ |
| Name/Address Confirmation | ✓ | ✓ | ✓ |
| Participation Day Request | ✓ | ✓ | ✓ |
| | | | |
| In this packet... | | | |
| FINAL REGISTRATION FORMS & OTHER REQUIREMENTS Due July 15 | | | |
| Proof of Child's birth date (e.g., copy of birth certificate, passport or visa) | ✓ | ✓ | |
| Copy of TB test result for <u>each</u> participating adult | Test must be within 1 year of start of school; chest xray required if skin test positive. | Test must be within 4 years. | Test must be within 4 years. |
| Parents' Statement of Health | ✓ | | |
| Personal Rights | ✓ | | |
| Parents' Rights | ✓ | | |
| Child's Preadmission Health History | ✓ | ✓ | |
| Consent for Emergency Medical Treatment | ✓ | ✓ | ✓ |
| DPNS Health and Safety Policy | ✓ | ✓ | ✓ |
| Identification & Emergency Information | ✓ | ✓ | ✓ |
| Physician's Report Any variance from state-recommended vaccinations requires immunizations waiver; speak to registrar. | ✓ Within one year of start of school | ✓ Within one year of start of school | ✓ Within one year of start of school |

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 |
|--|-------|---|-------|--|-------|
| <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'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 |
|--------------------|------|

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

()

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 |
|-------------------|-----------|

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.

DPNS HEALTH AND SAFETY POLICY

The Board and Association of Davis Parent Nursery School is concerned about the health and safety of all of our students. It is critical that directors be informed about any health or safety issues pertaining to either the working adults and/or their enrolled child(ren).

We are aware that individuals can have food and other allergies. Some of these allergies may be life threatening. It is the responsibility of the **PARENT** to make the director aware of any and all allergies they or their child might have and of the proper treatment should that individual be exposed to the allergen. This must be submitted in writing to the director prior to the individual attending class. Further, if an epi-pen is required, the family must provide two pens to the director in advance of the individual attending school or any other function on campus.

Should an enrolled student (adult or child) have a life threatening food allergy, that student shall not participate in the regular session snack, but rather the family shall be responsible for providing an alternate snack for themselves or their child. DPNS will make an effort to keep those life threatening foods out of the affected site; however, with both rotating session purchasers and working parents, DPNS cannot be responsible for guaranteeing that these items will never be present on campus.

IMPORTANT

Parents and parents of students with allergies or any other health conditions that may affect their safety or that of others at the school **MUST** participate in a pre-attendance conference with their director before their first school day at DPNS each year. Students who add midyear must submit their paperwork for review by the director and, if indicated, must schedule a meeting with the director prior to actual attendance.

Parents should also notify and confer with directors should their own or their child's health status change throughout the year.

Please Complete

I have read and understand the health and safety policy of Davis Parent Nursery School.

Parent Signature _____ Date _____

Please Circle One

I require a conference with my director. YES / NO.

If I answered **Yes** above, I realize it is my responsibility to contact my director and schedule a conference before the first day of school.

Parent Signature _____ Date _____