

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 15			
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

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 _____