IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Guardian – All sections must be completed

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	HOME TELEPHONE ( )
CHILD HOMES ADDRESS	ADDRESS	CITY	STATE ZIP	CHILD'S BIRTHDATE
FATHER'S NAME LAST	MIDDLE	FIRST		FATHERS CELL PHONE ( )
FATHER PLACE OF EMPLOYMENT	ADDRESS	CITY	STATE ZIP	FATHER WORK PHONE ( )
MOTHER'S NAME LAST	MIDDLE	FIRST		MOTHER'S CELL PHONE ( )
MOTHER PLACE OF EMPLOYMENT	ADDRESS	CITY	STATE ZIP	MOTHER'S WORK PHONE ( )
NAME OF PERSON CHILD LIVES WITH LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	ADDITIONAL CONTACT NUMBER ( )

Must have at least two (2) emergency contacts other than parents

NAME	ADDRESS	PHONE	RELATIONSHIP
1		CELL ALTERNATE	
2		CELL ALTERNATE	
		CELL ALTERNATE	
		CELL ALTERNATE	

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 OTHER THAN PARENTS

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

SIGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	DATE LEFT

STATE OF CALIFORNIA
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)

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

Carmel Valley Montessori School . This Child Care Center/School provides a program which extends from 7 : 30
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:00 p a.m./p.m. , 5 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)	/ /	/ /	/ /	/ /	/ /
DT/Td (DIPHTHERIA, TETANUS AND AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
(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: _____ Date of Physical Exam: ___
Address: _____ Date This Form Completed: _____
Telephone: _____ Physician Signature _____

LIC 701 (8/08) (Confidential)

Sick Policy

In order to maintain the health of our students and our staff, everyone must follow the sick policy at school. To ensure that we all remain healthy at school it is important to keep children home if they are not feeling well or have any communicable diseases. According to the State of California, if your child has any of the following symptoms they are not permitted to be at school and cannot return until they have been symptom and fever free for at least 24 hours:

- Continual drainage from nose, eyes, ears or mouth
- Diarrhea - more than 2 times in 24 hour period (must be symptom free for at least 24 hours before child can return to school)
- Vomiting within the last 24 hours (must be symptom free for at least 24 hours before child can return to school)
- Fever (over 100.4)
- Continuous coughing wet or dry
- Continuous sneezing
- Sore throat
- Undiagnosed rash or without physicians written verification
- Head lice, nits or scabies
- Red, itchy or watery eyes
- Open cold sores or wounds
- Ring worm, impetigo, conjunctivitis
- Lethargic

If we do notice that any child has any of these symptoms while at school they will be isolated from the rest of the students and will need to be picked up within 1 hour from the time parents are contacted. Any child that is not picked up within the hour will be charged $150 nursing fee for each two hour increment after the 1 hour grace period until child is picked up. Please do not give your child medication just to mask the symptoms so they can come to school; they may still be contagious and spreading germs. **Children must be symptom and fever free for a full 24 hours before they can return to school. Please note that if your child gets sent home from school they will not be able to return to school until they have been fever and symptom free for a full 24 hours.**

As always it is very important to ensure that your children have a well balanced diet, as well as making sure they are following all necessary precautions to avoid spreading germs. We apologize for any inconvenience this may cause, however we appreciate your continued support and respect for our staff and the rest of the students in our care. If we continue to follow these simple guidelines we will be able to maintain a healthier group of students. Please let me know if you have any questions or concerns regarding this matter.

--Please return this portion back to the office--

I have read and understand the sick policy for CVMS.

Child's Name:_____ Date:_____

Parent's Signature_____