Date enrolled _____

Withdrawn _____

Early Discoveries Child Development Center

Admissions Agreement

_____ _____ / / _____

Child's Name **Date of Birth**

____ Cambrian Park Center

____ Houge Park Center

2 -3 year olds

M-F	7:00 AM - 6:30 PM	$1400	____	M-F	7:00 AM - 1:00 PM	$900	____
MWF	7:00 AM - 6:30 PM	$1080	____	MWF	7:00 AM - 1:00 PM	$720	____
TTH	7:00 AM - 6:30 PM	$840	____	TTH	7:00 AM - 1:00 PM	$570	____

3 - 4 year olds

M-F	7:00 AM - 6:30 PM	$1200	____	M-F	7:00 AM - 1:00 PM	$820	____
MWF	7:00 AM - 6:30 PM	$925	____	MWF	7:00 AM - 1:00 PM	$660	____
TTH	7:00 AM - 6:30 PM	$735	____	TTH	7:00 AM - 1:00 PM	$520	____

4 - 5 year olds

M-F	7:00 AM - 6:30 PM	$1200	____	M-F	7:00 AM - 1:00 PM	$820	____
MWF	7:00 AM - 6:30 PM	$925	____	MWF	7:00 AM - 1:00 PM	$660	____
TTH	7:00 AM - 6:30 PM	$735	____	TTH	7:00 AM - 1:00 PM	$520	____

Kindergarten (Cambrian Park Center Only)

Full Day (7:00 AM - 6:30) $1200 ____ Kindergarten Only (8:30 AM – 3:30 PM) $1100 ____

Infant/Toddler 6 months – 2 years old (Houge Park Center Only)

M-F	7:00 AM - 6:30 PM	$1700	____
MWF	7:00 AM - 6:30 PM	$1300	____
TTH	7:00 AM - 6:30 PM	$1080	____

Drop-in Rate (space permitting for currently enrolled students)

$70/day Full Day

$35/Day Half Day staying Full Day (1:00pm – 6:30pm)

Sibling Discount: 10% off the Lowest Tuition Rate

Meals and Enrichment Programs are included at no additional cost.

Parent/Guardian 1

First Name: _____ Last Name: _____

Email address: _____

Business Phone Number: _____

Cell Phone Number: _____

Parent/Guardian 2

First Name: _____ Last Name: _____

Email address: _____

Business Phone Number: _____

Cell Phone Number: _____

Home Address (Child's primary address)

Address _____

City _____ State _____ Zip Code _____

Home Telephone _____

Early Discoveries CDC offers full and part-time preschool and kindergarten programs for ages 2 through First Grade entry and full-time infant/toddler care (6 months through 2 years old). Children are not required to be potty trained.

We do not discriminate against parents or children based on gender, race, religion or physical ability.

I hereby understand agree and to the following policies:

A non-refundable registration fee of $25.00 per child is payable at registration. A non-refundable deposit of half the first month's tuition is required to reserve a spot, which will be credited to your first month's tuition bill.

I will submit all required registration forms including a signed Physician's Report, & all emergency contact information and consent for treatment forms before my child can attend.

I will provide information on how to contact me in an emergency situation (including address, phone number, employment, and other emergency information). **I will update this information when changes occur.**

I understand tuition is based on a monthly rate and **no tuition refunds** due to illness, inclement weather, labor strikes, power and/or water outages, holiday closings or other legitimate conditions beyond the control of the center. Tuition is not decreased for holidays, vacations, early release days, training days, or absences.

Tuition is due the first of each month according to this agreement. There is a five working day grace period for payment. **A $25.00 late fee will be applied on the 6thworking day and each additional week thereafter until tuition is brought current.**

To give the preschool Director any changes in my child's schedule in writing 2 weeks prior to the effective change in schedule. Changes will be made on a space available basis.

A $25.00 fee will be billed for each returned check.

There will be a charge of $15.00 for first ten minutes late in picking up my child. **After 10** minutes the charge will be **$1.00 charge** for each additional minute. Payment is due immediately on pick up and child cannot return until fee is paid. (Lateness will be judged by the center's clock.)

A minimum of 30 days notice for withdrawal from the program must be given to the director in **writing**. If 30 days cannot be given, the parent is responsible for the tuition for the 30 days. Communication with administration is encouraged.

Parents will be given a minimum of 30 days notice to any changes in tuition or changes in this agreement.

Contracts may be terminated by the center's director, as a last resort when the school is no longer able to meet your child's or family's needs, failure to pay tuition or behavior that endangers the mental or physical well being of students or staff. You final tuition payment will be calculated based on the last month the child was enrolled.

To notify a teacher and sign in and out every time I, or someone I authorize, enters the center to drop off or pick up my child.

I understand my child will not be released to anyone other than a parent without prior written consent.

Children too sick to participate in full program activities (indoor and outdoor) need to be kept at home.
I understand the policy to keep my child at home according to the Early Discoveries CDC's Health Care Policy.

To notify the staff when my child is ill has a contagious disease or head lice.

To provide at least 2 complete sets of **extra clothes**, **a recent photo,** and to send a clean crib sheet each Monday for my child's rest cot. I understand this sheet should be taken home each Friday, when my child is ill or has and accident to be washed.

To discuss any concerns I may have with the Supervising Lead Teacher.

I will notify my child's teacher when my child is scheduled for routine health visits, and obtain a health form and immunization record to complete and return. **School health forms and immunization records must be updated annually to meet state requirements.**

I will be asked for written permission for each fieldtrip taken by the Early Discoveries CDC. I understand my child will not be able to attend without written consent

I understand that my child's Lead Teacher will conduct a developmental screening within three months of enrollment and that the results will be shared with me.

I understand that Early Discoveries CDC will keep ongoing assessments of my child as an integral part of the Program. Assessments are gathered through a variety of methods including observations, checklists, and anecdotal records; all information gathered therein will be collected and maintained in my child's portfolio, which is available to me at any time.

As a parent, I will be provided with information, either verbally or in writing, about my child's development and learning on at least a quarterly basis and with written reports at least two times per year.

To cooperate with the Supervising Lead Teacher in the follow up of any medical, dental, or developmental needs of my child.

I understand I must complete and sign a medication consent form when requesting medication be administered to my child.

I give permission to print parent name, (please Initial)_____ address, e-mail and phone number for the Early Discoveries CDC Directory. (Child's name will not be included.)

I understand my child may be photographed for print, video, or electronic imaging and may be used in promotional material, news releases, and other published format unless I complete a Photo/Video Permission form withholding permission. In addition to the initial application form, the following forms must be completed and submitted to the director or office manager prior to enrollment:
Emergency Consent for Medical treatment (LIC282)
Parent's Rights (LIC995)
Personal Rights (LIC613)
ID and Emergency Information
Health History
Physician's Report
Immunization Record
TB Test

Right of Licensing Agency
The State of California General Licensing Requirements, Section 101200 (b) & (c) states:
The Department or Licensing Agency has the authority to interview children, or staff, and to inspect and audit child or facility records without prior consent.
The Licensee shall make provisions for private interviews with any child(ren), or any staff member; and for the examination of all records relating to the operation of the facility.
The Department or Licensing Agency has the authority to observe the physical condition of the child/ren, including conditions which could indicate abuse, neglect, or inappropriate placement

I have received and read a copy of the Parent Handbook and agree to abide by all the rules and regulations

Signature: _____ **Date:** ____/____/____
Parent/Guardian

Signature: _____ **Date:** ____/____/____
Administration

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Early Discoveries CDC
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME
. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

LIC 627 (5/01) (CONFIDENTIAL)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Early Discoveries CDC
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME
. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

LIC 627 (5/01) (CONFIDENTIAL)

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: Community Care Licensing

   Licensing Office Address: 2580 N 1st St # 300, San Jose CA 95131

   Licensing Office Telephone #: (408) 324-2148

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

LIC 995 (9/08) (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.

Early Discoveries CDC
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

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

Community Care Licensing

ADDRESS

2580 N 1st St, Ste 300

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Jose	95131	(408) 324-2148

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)
Early Discoveries CDC	14381 Bercaw Ln, San Jose, CA 95124

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

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
☐ 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

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)

Early Discoveries CDC . This Child Care Center/School provides a program which extends from 7 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:30 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)	/ /	/ /	/ /	/ /	/ /
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:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ 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.

Early Discoveries CDC

Sunscreen Consent Form

Child's Name _____ Date of Birth _____

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for the staff at **Early Discoveries CDC** to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below when he/she will be playing outside.

I understand that sunscreens will be applied to exposed skin approximately 20-30 minutes before going outside, including but not limited to the face (except eyelids), top of ears, nose, bare shoulders, arms and legs.

I have initialed below **all** applicable information regarding the use of sunscreen for my child.

Please use the following brand/type of sunscreen I have provided for my child:

Name of sunscreen: _____

____ I do not know of any allergies my child has to sunscreen

____ My child is allergic to some sunscreens. Pleas use **ONLY** the brand/type of sunscreen I have specified for my child

____ For medical or other reasons, please **DO NOT** apply sunscreen to the following areas of my child's body:

_____

_____

_____ _____

Parent/Guardian's Signature Date

Early Discoveries CDC

Photo/Media Release Form

I give my permission for my child, _____,
(child's name)

to be photographed during school events for the purpose of publicizing the school's activities. I understand that this includes the web site, banners, advertisements and/or any other school functions.

Please check any/all that would apply to your child.

You have my permission to take my child's picture and/or videotape my child.
Yes _____ No _____

You have my permission to identify my child by first name only with the picture and/or video.
Yes _____ No _____

You have my permission to identify my child by first and last name with the picture and/or video.
Yes _____ No _____

_____
Parent/Guardian's Name (please print)

_____ _____
Parent/Guardian's Signature Date

I wish to withhold permission to photograph and/or video my child,

_____, **at this time**.
(child's name)

_____
Parent/Guardian's Name (please print)

_____ _____
Parent/Guardian's Signature Date

Early Discoveries CDC

Invoice Email Form

Child's Name_____

This form requests that you allow Early Discoveries CDC to send your invoice via email. Please read the agreement below and fill out the form. We will not share your email address with anyone else.

Permission Agreement

I hereby authorize Early Discoveries CDC to furnish to me the tuition invoice via e-mail at the email addresses indicated below.

I understand that it is my obligation to inform Early Discoveries CDC of any changes in my email addresses after the date noted below. Tuition is due on the 1st of the month. There is a five working day grace period for payment. A late fee of $25 will be applied on the 6th working day and each additional week thereafter until tuition is brought current. I am still responsible for paying tuition on time or with applicable late fees, regardless of not receiving my invoice due to not informing Early Discoveries CDC of a change in email address. I further understand that my information will remain confidential.

_____
Parent/Guardian's Name (please print)

_____ _____
Parent/Guardian's Signature Date

Primary Email address: _____

Additional Email address: _____

Early Discoveries CDC

Developmental History and Background Information

Child's Name _____ Date of Birth_____

Developmental History

Premature delivery? Yes_____ No_____ If yes, how early?_____

Age began Sitting _____ Crawling _____ Walking _____ Talking _____

Any speech, mental or physical difficulties? Explain:

_____

_____

_____

Special words to describe needs:

_____

_____

Health

Serious illness and/or hospitalizations _____

Special physical conditions, disabilities or allergies _____

Does your child take any medication daily? If yes please explain:

_____

Eating Habits

Special characteristics or difficulties:

_____

_____

Food Allergies:

_____

Child eats with: hands _____ spoon _____ fork _____

Toilet Habits

Is your child potty trained? Yes_____ No_____

How does your child indicate bathroom needs? (include special words)

_____

Is your child ever reluctant to use the bathroom? Yes_____ No_____

Does your child wet the bed? Yes_____ No_____ Diapers_____

Does your child wear diapers during the day time_____ night time_____ (pull-ups are considered diapers)

Sleeping habits

Does your child nap during the day? Yes_____ No_____ How long? _____

When does your child go to bed at night? _____ Wake in the morning? _____

Does you child sleep through the night? Yes_____ No_____

Describe any special characteristics, needs or bedtime routines (stuffed animals, story, songs, etc.)

_____

_____

Social Relationships

How would you describe your child socially?

_____

_____

_____

Is this your child's first formal group experience? Yes_____ No_____

If not, list the school and dates attended.

School: _____

Dates Attended: _____

Reaction to strangers:

_____

Ability to play alone? Yes_____ No_____

Favorite toys and activities:

Fears (the dark, animals, rough children, loud noises, etc.):

How do you comfort your child?

How do you discipline your child?

Describe your child's schedule on a typical day:

What would you like your child to gain from this experience?

Is there anything else you would like us to know about your child?

Please complete the questionnaire below. Mark the number which best describes how often your child's recent and current behavior reflects the scale from 1 – 4.

1= frequently 2= sometimes 3= rarely 4= almost never

My child…

_____ is moody for more than a few minutes when corrected or disciplined.

_____ laughs and smiles when playing.

_____ moves slowly when working on a project or activity.

_____ responds intensely to disapproval.

_____ needs a period of adjustment to get used to changes in school or home.

_____ enjoys games that involve running or jumping.

_____ is slow to adjust to change in the household rules.

_____ is willing to try new things.

_____ is able to sit during mealtime.

_____ reacts well to other children.

_____ responds to mild disapproval by the parent (frowns, shakes head, etc.)

_____ shows strong reaction to things, both positive and negative.

_____ has trouble leaving parent(s).

_____ falls asleep easily.

_____ moves about actively when he/she explores a new place.

_____ can sit and look at books.

_____ learns new things at his/her level quickly and easily.

_____ smiles or laughs when he/she meets visitors at home.

_____ is easily excited by praise.

_____ transitions well.

_____ practices an activity until he/she masters it.

_____ eats well

_____ shows an interruption of behavior when he/she notices an unusual sound (sirens, thunder, etc.)