

WISE SCHOOL

DUE August 20, 2014

GRADE LEVEL _____

EMERGENCY INFORMATION

TO THE DIRECTOR or SCHOOL NURSE: In case of a medical emergency, you are authorized to contact and, if necessary, release my child to any of the following:

Physician _____ Name _____ Address _____ Phone _____

Dentist _____ Name _____ Address _____ Phone _____

Relative _____ Name _____ Address _____ Phone _____

Neighbor _____ Name _____ Address _____ Phone _____

If Physician cannot be reached, what action should be taken?

____ Transport to Hospital

Other - Explain: _____

STEPHEN S. WISE TEMPLE AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I/We), the undersigned, parent(s) or Authorized Representative (s) of _____

a minor, do hereby give consent to Wise School Early Childhood to obtain all emergency medical or dental care prescribed by a duly licensed Physician (M.D.), Osteopath (D.O.), or Dentist (D.D.S.) in the case of an emergency. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of the child named above.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain in effect from SEPTEMBER through SEPTEMBER and will cover attendance at all authorized functions.

Signature of Parent 1 _____ Date _____

Signature of Parent 2 _____ Date _____

Guardian _____ Date _____

Signatures above authorize all information provided on this emergency card

Please check if you **DO NOT** want your address & phone included in the school roster

CHILD'S NAME _____ LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ Mo _____ Day _____ Year _____ Sex _____

Parent's Name _____ Parent 1 _____ Parent 2 _____

Address _____ Street _____ City _____ Zip _____

Email Address _____ Parent 1 _____ Parent 2 _____

Home Phone- Parent 1 () _____ Parent 2 () _____

Business Phone- Parent 1 () _____ Parent 2 () _____

Cell Phone- Parent 1 () _____ Parent 2 () _____

Person Responsible for Child _____

Additional Persons to call in an Emergency or Authorized person(s) to pick up child from School other than parents (INCLUDING CARPOOL)

Name _____ Relationship: _____
Phone # _____

Name _____ Relationship: _____
Phone # _____

Name _____ Relationship: _____
Phone # _____

Name _____ Relationship: _____
Phone # _____

SPECIAL INSTRUCTIONS FOR SCHOOL NURSE

Chronic Illness _____

Daily Medication _____

ALLERGIES _____

SYMPTOMS _____

TREATMENTS _____

Medication Form

This form must be returned before the beginning of the school year and whenever the prescription changes

Student Name: _____ Date of Birth: _____ Grade: _____

California Education Code 49423 allows the School Nurse or other designated school personnel to assist students who are required to take medication during the school day. Medication, including any over-the-counter medicines, may be administered only after the school receives the following:

1. Written instructions from the physician.
2. Written permission from the parent or legal guardian

PARENT PERMISSION

_____ I authorize the school nurse or other designated personnel to administer any prescription or non-prescriptive medication as ordered by my child's physician.

If YES, please have your physician complete the form below and sign. The form requires a parent signature as well.

_____ I request that **no** medication be administered to my child at school.

If NO, please sign and date the form and return it to school by August 23, 2013.

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Non-prescription medication(s) that may be administered according to labeled indications and directions:

Acetaminophen (i.e. Tylenol):	Yes _____	No _____
Ibuprofen (i.e. Advil, Motrin):	Yes _____	No _____
Benadryl (for allergic reaction only):	Yes _____	No _____
Sudafed (for congestion due to allergy or common cold without fever)	Yes _____	No _____
Other (i.e. Claritin, cough syrup, etc. – must be supplied by parent)	Yes _____	No _____

Prescription medication(s) that may be administered according to written directions below:

Medication _____ Diagnosis _____

Dosage, form, route _____ Time Schedule _____

Additional Instructions _____

Please print or stamp: Physician's Name: _____

Address: _____

Telephone: _____ FAX _____

Physician's Signature _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I understand that the administration of medications at school requires a physician's written order including non-prescriptive medications (i.e. Tylenol/Advil). I will comply with the policies and procedures determined by SSWT Schools. I recognize that the administration of medications is a service, which the School is not legally required to perform, and I agree to hold the school and its personnel free from all liability that may arise out of this service.

Parent/Legal Guardian'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)

_____. 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

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*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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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
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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?
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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
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**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: LA Childcare West

Licensing Office Address: 1667 Bristol Parkway #400, Culver City, CA 90230

Licensing Office Telephone #: 310.337.3752

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.

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

LIC 995 (9/08)

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

LA Childcare West

ADDRESS

1667 Bristol Parkway #400

CITY

Culver City

ZIP CODE

90230

AREA CODE/TELEPHONE NUMBER

310.337.3752

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)

Stephen S. Wise Temple, Early Childhood Center

(PRINT THE ADDRESS OF THE FACILITY)

15500 Stephen S Wise Drive, Los Angeles, 90077

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

WISE SCHOOL

ECC HEALTH POLICIES

Health Policy

Your child must be in GOOD health when left in our care. **Effective immediately: No child will be admitted to school upon morning drop off if they appear ill to the classroom teachers.** One teacher in the class will conduct a health screening upon morning drop off. If the teacher determines that a child does not look well, or, if the child or parent reports illness within the prior 24 hours, the child will NOT BE ADMITTED to class that day. Children must be symptom free for 24 hours before being readmitted to our camp. There will be no exceptions.

Do not send your child to school if:

- He/she has a contagious illness or is too sick to enjoy the school day
- He/she had a fever in the past 24 hours
- He/she vomited or had diarrhea in the past 24 hours

Teachers will be trained in conducting a health screening and will utilize the experience and expertise of our school nurse when necessary. Again, there will be no exceptions. If your child is asked not to attend class, we ask for your total and immediate cooperation. This is for your child's safety and well being, as well as for the health of our staff. Please do not send your child to school if he/she is sick.

If your child has a chronic illness or chronic allergies that appear to look like a cold, the child must have a physician's note on file in the school office indicating that the child is not ill and not contagious and that he/she may be admitted to school daily.

If your child develops a fever, diarrhea, vomiting or other symptoms that interfere with his or her ability to participate in our program we will contact you and ask that you pick up your child within one-hour. We expect your immediate cooperation in this matter.

You will be contacted immediately if any of the following symptoms are identified: Unusual spots or rash, sore throat, infected skin patches, unusually dark, tea-colored urine, gray or white stool, green colored mucus, headache and or stiff neck, unusual behavior or intense itching.

If your child becomes ill with a communicable disease, notify our office immediately. We will notify all parents in your classroom, and, when necessary, other classrooms when a child is diagnosed with: chickenpox, hand, foot & mouth disease, head lice and other childhood illnesses of these types. Your child will not be re-admitted to class until they have been checked by the school nurse and deemed healthy and non-contagious.

Notify our office of any serious illness or, if your child will be out of school for more than two days. We wish to support you and hope you will communicate your family's health issues whenever possible.

Scrapes and scratches are inevitable during children's play; these will be treated by the school nurse and your child will receive extra TLC from our staff! We will contact you immediately in case of serious injury and we expect your immediate response.

All staff employed at the ECC is trained in Emergency First Aid and Infant/Child CPR. Our recertification occurs in September.

Medication Policy – Nursery School

We are required by the State of California to inform you that ***any medication your child must take at school should be sent in its original pharmacy container with the following information: Child's name and complete instructions as to dispensing meds***

You must bring this medication to the school nurse's office. Once you have signed a CONSENT TO ADMINISTER MEDICATION form the School Nurse will administer the medicine. Aspirin will not be administered by our school under any circumstance. Note: We will only administer prescription medications – no over-the-counter meds are permitted.

Safety

The safety of our children, visitors, parents and staff is as important to us as it is to you.

Help us by abiding by these guidelines;

1. Your child's shoes must be appropriate for school. Please do not allow your child to wear flip-flops, platform heels, or "princess shoes" to school. Sandals that strap to your child's foot are permitted. Water shoes are welcome.
2. Extra snacks from home are not permitted during the school day. Discuss special arrangements with the administration and teacher if your child has allergies or dietary restrictions so that individual needs can be accommodated.
3. We ask that you report medical conditions to the office so we can assist your family with these special needs.
4. Children using bottles should be held close. We do not allow toddlers to walk around if they are using a bottle.
5. Please refrain from changing babies on the ECC classroom floors. There are changing tables provided in various locations and this will help us eliminate health hazards.
6. Keep your child home if he or she is sick.
7. If you do not wish for your child to be photographed or videotaped during the school day, send a letter stating this to our administration. We will alert the staff and when there are photographs or videotaping activities in your class, we will

honor your individual request. Whenever possible, we request permission from parents before photographing children at school.

8. We are unable to accommodate siblings during regular class time; they are welcome for Shabbat celebrations. We appreciate your understanding.
9. Caregivers may not bring children to our Parenting Center classes. If you are unable to attend with your child, a family member may attend in your absence.
10. Adult members of your immediate family are welcome to visit us. We request advance notice whenever possible so that we might prepare our teachers for additional bodies.
11. Do not bring children with adult visitors.
12. We ask that you refrain from using cell phones while driving and that you respect all posted signs around campus. Cell phones should be turned off, silenced, or put on vibrate if you are participating in a classroom.
13. Remember to hold your child's hand when exiting the car and walking to our gates.
14. We ask that you always close the gates behind you. This will prevent a child from leaving unsupervised.

I have received and will comply with the ECC Health Policies.

Signature

Date

Print Parent Name Room