Bright Horizons Back-up Child Care Registration Materials

Dear Parent

Enclosed please find Bright Horizons' Back-up Child Care Registration Materials. The information requested in these forms is required by Bright Horizons Family Solutions and municipal and state child care licensing authorities to ensure that each child has a safe and successful day at the center. All shaded information is required for full registration and must be provided before your child visits the center. If you have any questions about the enclosed registration forms please call Bright Horizons Back-up Child Care Toll-Free Registration Line 866-273-2773.

There are three ways to register:

- Online at www.brighthorizons.com/backup (Select Register My Child)
- By phone at 866-273-2773 or by calling your center directly
- By fax/mail complete the enclosed forms and fax or mail to your center

We look forward to serving your family!

You may submit your completed registration materials via fax mail or email. See below for your center's contact information.

Bright Horizons at UTC

9255 Towne Center Drive Suite 150 San Diego, CA 92121 (858) 458-0042 phone (858) 458-0596 fax utc@brighthorizons.com

Bright Horizons Irvine

2010 Main Street Suite 120 Irvine, CA 92614 (949) 261-1200 phone (949) 261-6880 fax irvine@brighthorizons.com

Bright Horizons Palo Alto

3000 El Camino Real Palo Alto, CA 94306 (650) 493-3777 phone (650) 493-3711 fax paloalto@brighthorizons.com

Bright Horizons at 2nd Street

303 2nd Street, 2nd Floor, Suite 250 San Francisco, CA 94107 (415) 495-2500 phone (408) 495-2507 fax 2ndstreet@brighthorizons.com

Bright Horizons at Los Gatos

220 Belgatos Road Los Gatos, CA 95032 408-356-7989 (phone) 408-365-5340 (fax) parents@brighthorizons.com

Bright Horizons Burbank

115 N. Hollywood Way Burbank, CA 91505 (818) 526-0580 phone (818) 526-0581 fax burbank@brighthorizons.com

Bright Horizons Los Angeles

550 South Hope Street Terrace Suite 235 Los Angeles, CA 90071 (213) 623-0072 phone (213)622-7693 fax losangeleshopestreet@brighthorizons.com

Bright Horizons San Francisco

555 California Street
San Francisco, CA 94104
(415) 392-7531 phone
(415) 392-7532 fax
sanfranciscocaliforniastreet@brighthorizons.com

Bright Horizons Family Center - Del Mar

3720 Arroyo Sorrento Road San Diego, CA 92130 (866) 273-2773 toll-free (858) 259-7213 fax parents@brighthorizons.com

Bright Horizons Back-up Child Care Registration Checklist



Child Name:	
Child Information Form	\neg
(one for each child to be registered)	
Participating Parent/Guardian Information Form	٦
(one for each participating guardian in the family)	
Non-Participating Parent/Guardian Information Form	٦
(one for each non-participating guardian in the family (if applicable))	
Authorization for Release and Emergency Medical Treatment	
(one for each child to be registered)	
Authorized Non-Parent/Guardian Information Form	
(one for each child to be registered)	
Medical and Insurance Information Form	\neg
(one for each child to be registered)	
Photograph of Child*	\neg
(see below for photograph requirements)	
Photograph of Parent(s)/Guardian(s)*	7
(see below for photograph requirements)	
Photograph(s) of Non-Parent/Guardian Authorized for Release*	
(see below for photograph requirements)	
CA Medical Form	٦
(one for each child to be registered)	
Pre-Admission Helath History - Parent's Report	٦
(one for each child to be registered)	
Registration Agreement	٦
(one for each child to be registered)	
Child Care Center Notification of Parent's Rights	
(one for each child to be registered)	
Personal Rights Child Care Facilities	

(one for each child to be registered)

^{*}Any photograph is acceptable (copy of drivers license or passport, family photo etc.) as long as the required parties are identified and the photograph is clear.

Bright Horizons Back-up Child Care Child Registration Information

Parent/Guardian Signature:



		Ī		
Child Name:	Child Date of Birth:			
(last, first, middle initial)	(/ / /) (mm/dd/yyyy)	Į		
Child Nickname:	Child Gender:			
Simulation and the second seco	Male Female			
	(please circle)	l		
Does your child have any allergies or food restrictions	?	yes	no	(please circle)
If yes, please describe:				
				(.1
Does your child have any diagnosed special needs or n	nedical conditions?	yes	no	(please circle)
If yes, please describe:				
Are your child's activities restricted by any special nee	eds, medical or other conditions?	yes	no	(please circle)
If yes, please describe:				
Child Lives With:				
Are there any custody arrangements for your child?		yes	no	(please circle)
If yes, please describe:				
(A court order with supporting documentation describing custod	dy arrangements and restrictions must be	provide	d.)	
Pogular Caro Arrangomento				
Regular Care Arrangements:				
Child's Primary Language:				
School Attending:				
(for pre-school and school age children only)				
Sleeping Schedule:				
(for children under 36 months only)				
Toilet Schedule:				
(for children under 36 months only)				
Siblings: (Please list names and ages)				
(Please list liallies allu ages)				
Other Helpful Information:				
lacktriangledown shaded information is required for full registration	and use of a Bright Horizons back-	ap child	d care	e center

Date:

Bright Horizons Back-up Child Care Participating Parent/Guardian Information Form

Parent/Guardian Signature:



A participating parent/guardian is a parent/guardian who has access to Bright Horizons back-up child care through his or her employer. If both parents are participating guardians please complete two Participating Parent/Guardian Information Forms.

Parent/Guardian General Information	า	
Parent/Guardian Name:	Relation to Child:	Gender
		Male Female
(last, first, middle initial)	-	
Employer (Company Name):		Employee ID #:
		ess your family's registration and ormation online?
Work Email Address		
	yes (please circle)	no
Job Category:	Job Type:	Job Title:
Administrative/Support Mid-Level Professional	Full Time Part Time	Job Haei
(please circle)	(please circle)	
Business Unit, Department or Subsidiary:		
Work Contact Information		
Work Address Line 1	Work Phone	Work Extension
	() -	
Work Address Line 2	Work Fax	
	() -	
Work Address Line 3	Work City, State, Zip	
Home Contact Information		
Home Address Line 1	Home Phone	Cell Phone
	() -	() -
Home Address Line 2	Home Email	
Home Address Line 3	Home City, State, Zip	
 shaded information is required for full registrat 	tion and use of a Bright Horizons	back-up child care program

Date:

Bright Horizons Back-up Child Care Non-Participating Parent/Guardian Information Form

General Parent/Guardian Information



A non-participating parent or guardian is a parent or guardian who does not have access to Bright Horizons backup child care through his or her employer.

Parent/Guardian Name:	Relation to Child:	
(last, first, middle initial)		
Employer (Company Name):		
Work Email Address		
Work Contact Information (Required if	applicable)	
Work Address Line 1	Work Phone	Work Extension
	() -	
Work Address Line 2	Work Fax	
W. J. A. J. A. J	() -	
Work Address Line 3	Work City, State, Zip	
Home Contact Information		
Home Address Line 1	Home Phone	Cell Phone
	() -	() -
Home Address Line 2	Home Email	
Home Address Line 3	Home City, State, Zip	
	,, , ,	
shaded information is required for full registration	and use of a Bright Horizons	back-up child care program
Parent/Guardian Signature:	Date:	

Bright Horizons Back-up Child Care Parent/Guardian Authorization for Release of Child and Emergency Medical

Non-Parent/Guardian Information Form



Child Name:			

California requires that each child have at least 1 person(s) other than the child's parent(s) or guardian(s) authorized for release and 1 person(s) authorized to make medical decisions in the event of an emergency.

of an emergency.	
Parent/Guardian Authorization for Ro	elease of Child:
I authorize Bright Horizons to contact and/o designated by me for this purpose:	or release my child to the following representative(s)
Authorized Non-Parent/Guardian Name:	
Parent/Guardian Signature:	Date:
Please provide contact information for autho Non-Parent/Guardian Information Form	orized non-parent/guardians on the Authorized
Horizons staff to administer first aid to my conotify me of any actions taken. For all other Horizons staff will attempt to contact me as reached, I authorize Bright Horizons to contact on my behalf for this purpose. If my rep	mergency Medical Treatment: ained in basic first aid and CPR. I authorize Bright child for minor injuries or illnesses as appropriate and to r conditions requiring emergency medical treatment, Bright the nature of the emergency permits. If I cannot be eact the following representative(s) designated by me to bresentative cannot be reached, I authorize Bright Horizons I or other medical facility and obtain any necessary medical
Parent/Guardian Signature:	Date:
Please provide contact information for autho	orized non-parent/guardians on the Authorized

Bright Horizons Back-up Child Care Authorized Non-Parent/Guardian Information Form

Parent/Guardian Signature:



An authorized non-parent/guardian is someone other than the parent(s) or guardian(s) who is authorized to pick the child up and/or make medical decisions for the child in the event of an emergency when the parent(s) or guardian(s) cannot be reached.

Ciliu Naille.				
California requires that each child ha or guardian(s) authorized for release in the event of an emergency.		-	_	
Authorized Non-Parent/Gu	uardian 1			
Authorized Non-Parent/Guardian Name:		Relationship to ch	ild:	
(last, first, middle initial)				
Work Phone: (if applicable)	Cell Phone: (if applicable)		Home Phone:	
() -	() -		()	-
Authorized for emergency medical decisions?:	•	Authorized for rele	ease of child?:	
	lease circle)	yes	no	(please circle)
Authorized Non Parent/Gu	uardian 2			
Authorized Non-Parent/Gu	uai uiali Z			
Authorized Non-Parent/Guardian Name:		Relationship to ch	ild:	
(last, first, middle initial)				
	Cell Phone: (if applicable)		Home Phone:	
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Work Phone: (if applicable) () -	() -		()	-
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Authorized for emergency medical decisions?: yes no (pl	: lease circle)		no	- (please circle)
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Authorized for emergency medical decisions?: yes no (plus) Authorized Non-Parent/Guardian Name: (last, first, middle initial)	: lease circle)	yes	no	- (please circle)
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Date:

Bright Horizons Back-up Child Care Medical and Insurance Information



Address Line 1	Doctor/Clinic Phone () - ()	-
Address Line 2	Address Line 3	
City, State, Zip		
Medical Insurance Information		
Medical Insurance Carrier:	Membership ID #:	
Name of Employer Providing Insurance:	Member Services Phone () -
Affiliate/Preferred Hospital:	Hospital Phone ()	-
Dentist Information		
Dentist Name:		
Address Line 1	Dentist Phone () - Dentist Fax ())	-
Address Line 2	Address Line 3	
Address Line 2 City, State, Zip	Address Line 3	
City, State, Zip	Address Line 3	

Bright Horizons Back-up Child Care Parent/Guardian Consents and Registration Agreement



Child Name:					
Parent/Guardian Conse	ents				
Parent/Guardian Consol give permission for my			nd educational purpose	es with Bright Horizons s	staff.
	yes	no (please ci	rcle)		
Parent/Guardian Signatu	re:			Date:	
Parent/Guardian Consortium I give permission for my training, curriculum, mark	child to be photograph	ed and videotape			er educational,
	yes	no (please ci	rcle)		
Parent/Guardian Signatu	re:			Date:	
Registration Agreemen	t				
I understand and agree	e to the following:				
1. Completion of Registra will notify Bright Horizons of my child. Medical, fam for registration. Addition Where applicable, all regimy child and use of the Complete the comp	and update all medically and other informated registration informated ration fees and/or pe	al, family and oth ion may be share tion or materials	ner information previou ed among Bright Horizo may be needed to cor	usly provided as part of toons child care centers who may be with local licensing	the registration here necessary requirements.
2. Parent Handbook; Police and related information of Center in accordance with Center. Use of the Center Agreement, or when deter availability of the Center	oncerning the Center a the terms of the Pare r and the backup child rmined by Bright Horiz	and the backup cent Handbook and care services mazons to be in the	hild care services prov d Bright Horizons polic ay be denied in the ev best interests of my c	ided by Bright Horizons. ies and procedures mad ent I do not comply with hild or the children using	I will use the e available at the the terms of this
3. No Employment. I will care or similar services ur any employee of Bright H under contract with Brigh	nder any circumstance orizons or person who	s without the exp within one year	oress consent of Bright of the date of such em	t Horizons. If I employ on the street of the	or contract with
4. Release of Bright Horiz Bright Horizons Children's claims, losses, damages or participation in the pro willful misconduct of Brigh companies, directors, offi	Centers, Inc., and the or costs (including atto grams and activities cont ht Horizons Family Sol	eir related compa orneys' fees) caus onducted by Brig utions, Inc., Brig	anies, directors, officer sed by or arising from ht Horizons other thar	s, employees and agent my child's registration, u to the extent caused by	s, from any use of the Center, y the negligent or
5. Release of Employer. my employer's employees services provided by Brig officers, employees and a my child's registration, us	and other participant nt Horizons. In consid gents, from any claim	s. My employer eration of the re- s, losses, damag	is not responsible for t gistration of my child, es or costs (including a	the Center or the backup I release my employer, attorneys' fees) caused l	child care and its directors, by or arising from
Parent/Guardian Signatu	ro.			Date:	

Rights of the Licensing Agency (Section 101200 (b) & (c):

The Department or Licensing Agency shall have 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 children or staff members. The Department has the authority to inspect, audit, and copy child or child care center records upon demand during normal business hours. Records may be removed if necessary for copying.

Childs Name:	
Signature of Parent/Guardian:	
Date:	
Signature of Center Director:	
Date:	

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

Series Date Series Serie								BY PARENT		الحموس	
AMERICATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.) VACINE VA	(NAME OF CHILD)		, born		(BIRTI	I DATE)		is being	stualea to	r readines	s to ente
a.m./p.m. toa.m./p.m. ,			This	s Child Ca	re Center	/School pi	rovides a	a program wh	ich exten	ds from	:
Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in thireport to the above-named Child Care Center. [Indext] [Ind											
PART B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN) PART B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN) Problems of which you should be aware: Hearing: Allergies: medicine: Vision: Inseed stings: Developmental: Poot: Language/Speedt: Asthma: Comments/Explanations: MEDICATION PRESCRIBEDUSPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.) VACCINE VACCINE DATE EACH DOSE WAS GIVEN VACCINE 1st 2nd 3rd 4th 5th POLIO (OPV OR IPV) / / / / / / / / / / / / / / / / / /											
PRATE B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN) Problems of which you should be aware: Hearing: Allergias: medicine: Insect stings: Developmental: Food: Language/Speech: Asthma: Definal: 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 VACCINE 1st 2nd 3rd 4th 5th POLIO (OPV OR IPV) / / / / / / / / / / / / / JOTIPITAR (OPPITHENA TETANUS AND DATE EACH DOSE WAS GIVEN VACCINE 1st 2nd 3rd 4th 5th POLIO (OPV OR IPV) / / / / / / / / / / / / / / / / / / /			ising the f	orm belov	v. I hereby	∕ authorize	e releas	e of medical	informatic	n containe	d in this
Problems of which you should be aware: Hearing: Allergles: medicine: Insect stings: Developmentalb: Pood: Language/Speech: Ashma: Developmentalb: 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 POUT/PIDTAPY (INCLUDIAN) RETURNS AND 10/21/21 / / / / / / / / / / / / / / / / /		(SI	GNATURE OF	PARENT, GUA	RDIAN, OR C	HILD'S AUTHO	RIZED REF	PRESENTATIVE)		(TODAY	"S DATE)
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IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.) VACCINE DATE EACH DOSE WAS GIVEN	Other (Include behavioral concerns):										
IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.) VACCINE DATE EACH DOSE WAS GIVEN	Comments (Euplemations)										
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DTP/DTaP/ (DIPHTHERIA, TETANUS AND (ACELULAR) PERTUSSIS OR TETANUS / / / / / / / / / / / / / / / / / / /	VACCINE	1:	st	21	nd	31	rd	4tl	1	5t	h
CACELLULAR] PERTUSSIS OR TETANUS	POLIO (OPV OR IPV)	1	1	1	1	1	1	1	1	1	1
(REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B) MARICELLA (CHICKENPOX) VARICELLA (CHICKENPOX) CREENING 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: Date This Form Completed: Signature	DIP/DIAP/ [ACELLULAR] PERTUSSIS OR TETANUS	1	1	1	1	1	1	1	1	1	1
HIB MENINGITIS (HAEMOPHILUS B) / / / / / / / / / / / / / / / / / /	MMR (MEASLES, MUMPS, AND RUBELLA)	1	1	1	1						
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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: Date of Physical Exam: Signature Signature	VARICELLA (CHICKENPOX)	1	1	1	1						
☐ 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		20 (1:-1:									
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Telephone: Signature					_ Date	This Form	Comple	ted:			
J Physician J Physician's Assistant J Muras Brastiti											
AND THE PROPERTY OF THE PROPER	Telephone:				_ Signa	ture					

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.

DATE

COMMUNITY CARE LICENSING CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? DATE OF LAST PHYSICAL/MEDICAL EXAMINATION DEVELOPMENTAL HISTORY (*For infants and preschool-age children only) TOILET TRAINING STARTED AT* BEGAN TALKING AT* WALKED 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 П Ten-Day Measles Asthma П **Epilepsy** (Rubeola) Rheumatic Fever Whooping cough Three-Day Measles (Rubella) Hay Fever Mumps SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS HOW MANY IN LAST YEAR? LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF □ NO T YES DOES CHILD HAVE FREQUENT COLDS? DAILY ROUTINES (*For infants and preschool-age children only)
WHAT TIME DOES CHILD GET UP?* DOES CHILD SLEEP WELL? WHAT TIME DOES CHILD GO TO BED?* DOES CHILD SLEEP DURING THE DAY?* WHEN?* HOW LONG?* DIET PATTERN: BREAKFAST WHAT ARE USUAL EATING HOURS? (What does child usually BREAKFAST eat for these meals?) LUNCH DINNER DINNER ANY FOOD DISLIKES? ANY EATING PROBLEMS? IS CHILD TOILET TRAINED?* IF YES, AT WHAT STAGE:* ARE BOWEL MOVEMENTS REGULAR? WHAT IS USUAL TIME?* YES 11 NO YES NO WORD USED FOR URINATION* WORD USED FOR "BOWEL MOVEMENT"* 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: П YES YES NO NO DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? IF YES, WHAT KIND: DOES CHILD USE ANY SPECIAL DEVICE(S): F YES WHAT KIND П П NO YES 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?

LIC 702 (8/08) (CONFIDENTIAL)

PARENT'S SIGNATURE

BEASON FOR REQUESTING DAY CARE PLACEMENT

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.
- File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
- 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.
- 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:
	Licensing Office Address:
	Licensing Office Telephone #:
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 (9/0	8) (Detach Here - Give Upper Portion to Parents)
AC	(NOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)
I, the p	arent/authorized representative of, have
	ed a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the GIVER 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

PERSONAL RIGHTS

Child Care Centers

LIC 613A (8/08)

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:
 - 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 ADDRESS CITY ZIP CODE AREA CODE/TELEPHONE NUMBER **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 ADDRESS OF THE FACILITY) (PRINT THE NAME OF THE FACILITY) (PRINT THE NAME OF THE CHILD) (SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN) (TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) (DATE)

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

AN (M.D.) OSTEOF	PATH (D.O.) OR DENT				
	THIS CARE MAY BE (GIVEN UNDER			
O PRESERVE THI	E LIFE, LIMB OR WE	LL BEING OF THE CHILD			
ES:					
	PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE				
WORK PHONE					
	WORK PHONE	PARENT OR AUTHORIZED			

LIC 627 (9/08) (CONFIDENTIAL)

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

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	it or Authorized Repre	MIDDLE		FIRST	SEX	Tyrice	HONE	
CHILU'S NAME LAST		MIUULE		Finot		SEA	TELEPHONE ()		
ADDRESS	NUMBER	STREET		CITY	STATE	ZIP	BIRTH	DATE	
FATHER'S/GUARDIAN'	S/FATHER'S DOMEST	IC PARTNER'S NAME LAST	MIDE	DLE	FIRST		BUSIN	ESS TELEPHONE	
					()		
HOME ADDRESS	NUMBER	STREET	STREET		STATE	ZIP	HOME TELEPHONE		
MOTHED COMARDIAN	PS/MOTHER'S DOMES	STIC PARTNER'S NAME LAST	MIDDLE		FIRST		(DITCH) ERR TELEBLONE	
MOTHER S/GUARDIAN	SYMOTHER'S DOMES	STIC PARTNERS NAME CAST	S NAME (AS) MIDDLE				BUSINESS TELEPHONE ()		
HOME ADDRESS	NUMBER	STREET		CITY	STATE	ZIP	HOME	TELEPHONE	
					<u> </u>		()	
PERSON RESPONSIBLE FOR CHILD LAST NAME		LAST NAME	MIDDLE FIRST H			OME TELEPHONE		BUSINESS TELEPHONE	
		ADDITIONAL F	PERSONS WHO	MAY BE CALLE					
	ADDITIONAL PERSONS WHO MAY BE CALLED						ONE DELATIONOUS		
	NAME		ADDRESS			TELEPHONE		RELATIONSHIP	
		PHYSICIAN	OR DENTIST T	O BE CALLED II	N AN EMERGEN	ICY			
PHYSICIAN		ADDRE				N AND NUMBER	TELEP	HONE	
						()		
DENTIST		ADDRE	ESS .		MEDICAL PLAN	N AND NUMBER	TELEP	HONE	
IF PHYSICIAN CANNO	T BE REACHED, WHA	T ACTION SHOULD BE TAKEN?						· /	
CALL EMERG	SENCY HOSPITAL	OTHER EXP	LAIN:						
		NAMES OF PERS		ZED TO TAKE CH	IILD FROM THE	FACILITY			
(СНІЦ	D WILL NOT BE ALL	LOWED TO LEAVE WITH ANY (RIZED REPI	RESENTATIVE)	
NAME				RELATIONSHIP					

TIME CHILD WILL BE	CALLED FOR								
SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE							DATE		
	TO BE COM	DI ETED DV FAOR IT	/ DIDECTOR's	DAINIOTO 1705		· · · · · · · · · · · · · · · · · · ·			
DATE OF ADMISSION	TO BE COM	PLETED BY FACILITY	DIRECTOR/AL	DMINISTRATOR/	FAMILY CHILD C	ARE HOM	ES LICE	NSEE	
LIC 700 (8/08)(CONFIL	DENTIAL)			1				The second secon	