

# Emergency Card

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Mom's Home # \_\_\_\_\_ Father's Home# \_\_\_\_\_  
Mom's Work# \_\_\_\_\_ Father's Work# \_\_\_\_\_  
Cell# \_\_\_\_\_ Cell# \_\_\_\_\_

If we are unable to contact parents in an emergency, contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Allergies: \_\_\_\_\_

Home Church # \_\_\_\_\_ Pastor's Name \_\_\_\_\_

Names of persons authorized to pick up child:

1. \_\_\_\_\_ Phone # \_\_\_\_\_
2. \_\_\_\_\_ Phone # \_\_\_\_\_
3. \_\_\_\_\_ Phone # \_\_\_\_\_
4. \_\_\_\_\_ Phone # \_\_\_\_\_

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

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

\_\_\_\_\_ 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

( )

# Shepherd Center

15215 E. Janine Dr. Whittier, Ca 90605

Dear Parent

Thank you so much for choosing our school. We would like you to bring the following items on your child's first day of school. Thank you!

## **Napping Items: (Day Care Students)**

All items labeled with child's first and last name

- \* Small Blanket
- \* Crib Sheet
- \* Small Pillow (optional)

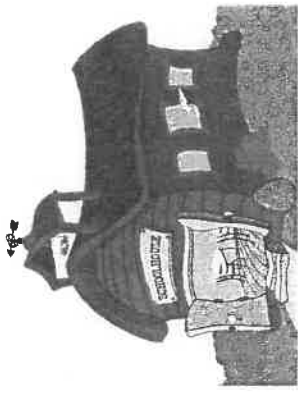
## **Extra Clothes:**

All items labeled with child's first and last name

- \* Shirt
- \* Pants or shorts
- \* Socks
- \* Underwear
- \* Diapers and wipes for non-potty trained

## **Breakfast:**

- \* Children can bring Breakfast to eat here at Shepherd
- \* Children can only eat breakfast between the hours of-6:30-8:00
- \* Every classroom has a microwave, we can warm up their breakfast if needed



## **Lunch:**

- \* Each child needs to bring his or her own Lunch each day
- \* Please mark the lunch box or lunch bag clearly with your child's name
- \* Please refrain from sending junk food
- \* Every classroom has a microwave, we can warm their lunch if needed
- \* No T.Y. Dinners
- \* Ice pack, if it needs to be refrigerated

## **Other Important Items:**

- \* Complete Enrollment package, Registration Fee, Tuition & Immunization Card
- \* And lot's of Kisses and Hug's for your child's first day!!!!

**Welcome!**

# Shepherd Center Preschool

(562) 693-8969

Days	Day Care		Preschool	
	(6:30 am - 6:00 pm)	*n/p	(9:00 am - 12:00 pm)	*n/p
5	\$645	\$665	5	\$540
3	\$470	\$495	3	\$348
2	\$370	\$395	2	\$305
				\$560
				\$368
				\$320
				\$10.50 per hour

Extra Day Charge \$60.00      Extra Day Charge \$50.00

These prices are per month.

We require a registration fee of \$140 and \$95 material fee for each NEW student, and a \$140 annual renewal fee and \$95 material fee for CONTINUING students.

(due with August tuition)

Tuition, registration and material fees are non-refundable upon termination.  
\* n/p non-potty trained \* p/t potty trained

## Registration Form

Today's date \_\_\_\_\_ E-Mail \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Church \_\_\_\_\_

Is your child potty trained? Yes \_\_\_\_\_ No \_\_\_\_\_

My child will begin at Shepherd Center \_\_\_\_\_ (start date)

My child is allergic to \_\_\_\_\_

Circle one:      My child will attend      PRESCHOOL      or      DAY CARE

Circle days:      Monday      Tuesday      Wednesday      Thursday      Friday

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

To Be Completed by Parent or Authorized Representative

CHILD'S NAME		MIDDLE		FIRST		SEX	TELEPHONE
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	( )	( )
FATHER'S NAME		MIDDLE		FIRST		BIRTHDATE	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BUSINESS TELEPHONE	
						( )	( )
MOTHER'S NAME		MIDDLE		FIRST		HOME TELEPHONE	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	( )	( )
						BUSINESS TELEPHONE	
PERSON RESPONSIBLE FOR CHILD		MIDDLE		FIRST		HOME TELEPHONE	
	LAST NAME			STATE	ZIP	( )	( )
						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 OR AUTHORIZED REPRESENTATIVE \_\_\_\_\_

DATE

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

DATE OF ADMISSION \_\_\_\_\_

DATE LEFT \_\_\_\_\_

# CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME \_\_\_\_\_ SEX \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ DOES FATHER LIVE IN HOME WITH CHILD? \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ DOES MOTHER 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 \_\_\_\_\_ TOILET TRAINING STARTED AT\* \_\_\_\_\_ MONTHS \_\_\_\_\_

BEGAN TALKING AT\* \_\_\_\_\_ MONTHS \_\_\_\_\_

**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

ILLNESSES	DATES	DATES	DATES
<input type="checkbox"/> Chicken Pox			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Rheumatic Fever			
<input type="checkbox"/> Hay Fever			
SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS _____			
<input type="checkbox"/> Diabetes			<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Epilepsy			<input type="checkbox"/> Ten-Day Measles (Rubecola)
<input type="checkbox"/> Whooping cough			<input type="checkbox"/> Three-Day Measles (Rubella)
<input type="checkbox"/> Mumps			

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 DURING THE DAY? \_\_\_\_\_ WHEN? \_\_\_\_\_ DOES CHILD SLEEP WELL? \* \_\_\_\_\_ HOW LONG? \* \_\_\_\_\_

DIET PATTERN: BREAKFAST \_\_\_\_\_ WHAT ARE USUAL EATING HOURS? \_\_\_\_\_

LUNCH \_\_\_\_\_ LUNCH \_\_\_\_\_

DINNER \_\_\_\_\_ 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)? 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? 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 \_\_\_\_\_

## 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, telephone number, and e-mail address of the local licensing office.

Licensing Office Name: Department of Social Services  
Community Care Licensing Division  
 Licensing Office Address: Los Angeles Child Care East  
1000 Corporate Center Dr., Ste 200-B  
Monterey Park, CA 91754

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.**

LIC 995 (8/02)

(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.

\_\_\_\_\_  
 Signature (Parent/Authorized Representative) \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Child Care Center

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.**

**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	Department of Social Services		
ADDRESS	Community Care Licensing Division		
	Los Angeles Child Care East		
	1000 Corporate Center Dr., Ste 200-B		
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 NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)



**Shepherd Center  
Handbook Amendment  
Fundraising Policy**

Shepherd center is a non-profit school. We strive to keep our tuition at an affordable rate to accommodate all families. We do provide the teachers pay increases as well as offer them medical benefits. Therefore we find it necessary to do fundraisers each school year. The money that is made from our fund raising efforts is always put back into our program either to purchase new items for our classrooms or playground. We rely on 100% parent participation in at least two fundraising events per school year with a minimum of fifty dollars per order or participate in two eight hour work days. If you cannot or do not wish to participate in these opportunities then you have the option to pay a fifty dollar donation two times per school year. These payments can be made at time of enrollment or are due at the time of our winter and spring fundraising events.

By signing below you agree to either participate in our fundraisers or use the alternate giving program of \$100.00 as a term of accepting our enrollment conditions.

.....

(Cut and Return lower portion.)

I have read and understand that by enrolling my child at Shepherd Center School I agree to participate in at least two fundraising events to total \$100.00 in sales or participate in two eight hour work days. If I choose not to participate in neither, I will donate two payments of \$50.00 each due at the time of their winter and spring fundraising events.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**SHEPHERD PRESCHOOL**

**MANDATED STATEMENT ACKNOWLEDGING REQUIREMENT  
TO REPORT SUSPECTED CHILD ABUSE**

Section 11166 of Penal Code Requires any child care custodian. Medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom her or she knows or reasonably suspects has been the victim of child abuse, or as soon as practically possible, by telephone and to prepare a written report thereof within 36 hours or receiving the information concerning the incident.

“Child Care Custodian” includes teachers, licensed day workers. Administration of community care facilities licensed to care for children, foster parents and group home personnel.

I, \_\_\_\_\_ parent or guardian of \_\_\_\_\_,  
Have read and understand the requirements of Penal Code Section 11166 as outlined and understand that employees of this facility are mandated by this requirement and will comply with these provisions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# SHEPHERD CENTER PRESCHOOL PHOTO RELEASE FORM

I, \_\_\_\_\_, the parent of a child/children at \_\_\_\_\_  
(Hereinafter known as the Shepherd Center), agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at the Daycare during normal daycare hours, field trips, or activities. I understand that these photographs may be used either in print or on the Internet for school use only.

The child(ren) are known as: \_\_\_\_\_.

With my signature below I grant permission for my child(ren) to be photographed, or their images recorded for print or on the Internet for school use only. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Parents we have created an Instagram Account to post our special events that take place throughout the school year! We are very excited about this and hope you all feel the same way, be if you don't, we respect your wishes. Please fill out and return as soon as possible! Thank you so much!

Instagram @shepherd\_center\_preschool



**PHYSICIAN'S REPORT—CHILD CARE CENTERS  
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)**

**PART A - PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

(NAME OF CHILD) SHEPHERD CENTER, born \_\_\_\_\_, is being studied for readiness to enter  
 (NAME OF CHILD CARE CENTER/SCHOOL) WHITIER, CA 90605 This Child Care Center/School provides a program which extends from  
 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: \_\_\_\_\_  
 Vision: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_  
 Developmental: \_\_\_\_\_ insect stings: \_\_\_\_\_  
 Language/Speech: \_\_\_\_\_ food: \_\_\_\_\_  
 \_\_\_\_\_ asthma: \_\_\_\_\_  
 \_\_\_\_\_ other: \_\_\_\_\_  
 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/DTP/DTaP/DT/DTd (DIPHTHERIA, TETANUS AND ACELLULAR PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY (MENOPHILUS 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 \_\_\_\_\_