
# World Of Discovery Required Licensing Forms Packet 2020-21

1. Identification and Emergency Information
2. Child's Preadmission Health History – Parent's Report
3. Physician's Report – Child Care Centers (2 pages)**
4. Personal Rights
5. Child Care Center Notification Of Parent's Rights
6. Consent For Emergency Medical Treatment-Child Care Center
7. Liability Waiver, Authorization and Consent To Photograph AND for Field Trips
8. World Of Discovery Preschool Admission Agreement 2020-2021

**IMPORTANT – **Physician's Report form** needs a doctor's office signature or stamp.
WOD is a licensed preschool with 8 forms required by the State Of California. The Physicians Report form may be a 1-3 day turnaround depending on the medical facility. A physician, nurse practitioner or nurse must sign or stamp the form. You do not need a doctor's appt. unless immunizations are not up to date. WOD cannot accept the 'yellow' immunization card because they are not always kept up to date. Your medical office can fax the form to LGS Recreation, Attn: Teri Fogarty, (408) 775-8366 (fax).

World of Discovery Preschool, (408) 867-4683 (phone)

# 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 |
|---|---|

# 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?) | | WHAT ARE USUAL EATING HOURS? |
|---|---|---|
| | BREAKFAST | BREAKFAST _____ |
| | 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)? ☐ 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)

World of Discovery Preschool . 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:_____ 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.

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Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

# 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

111 North Market Street, Ste: 300

| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
|---|---|---|
| San Jose, CA | 95113 | (408) 277-1286 |

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) |
|---|---|
| World of Discovery Preschool | 13200 Shadow Mountain Drive, Saratoga, CA |

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

| (TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | (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 and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 111 North Market Street, Ste: 300

   Licensing Office Telephone #: (408) 277-1286

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.

World of Discovery Preschool
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***

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

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

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

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 |
|---|---|
| (  ) | (  ) |

**Waiver of Claims/Assumption of Risk/Consent to Photograph/Video**
**LGS RECREATION** ***Los Gatos-Saratoga Community Education and Recreation***

**Participant Name**: _____

**Participant Name**: _____

**Address**:_____ **City**:_____ **Zip**:_____

The undersigned, in consideration of participation in the programs operated by Los Gatos –Saratoga Community Education and Recreation (LGS Recreation), agrees to indemnify and hold LGS Recreation , its Board of Directors, contractors, employees and volunteers harmless and release LGS Recreation , its Board of Directors, contractors, employees and volunteers from any and all liability for any injury which may be suffered by the named individual(s) registered in any program operated by LGS Recreation, arising out of, or in any way connected with participation in such program. I have read the above application and agreement, and fully understand that I assume all risks for any injuries received.

*Model Release: I release the photographer and LGS Recreation from liability for any violation of any personal or proprietary right I have in connection with any reproduction of or use of photographs in which I appear. I consent to the reproduction or use of photographs, without my name (or other registered participants), taken of me while participating in LGS recreation programs. LGS Recreation and its photographer will only take photographs and videos in a public setting in which there is a reasonable expectation of privacy*.

This Waiver of Claims/Assumption of Risk/Consent applies to future participation in all programs of LGS by all signatories and minors on whose behalf it has been signed.

**ADULT PARTICIPANTS**, INCLUDING THOSE PARTICIPATING IN PARENT-CHILD CLASSES, SIGN BELOW

Signature: _____ Print Name: _____ Date: _____
Signature: _____Print Name: _____ Date: _____

TO BE COMPLETED BY PARENT OR **GUARDIAN OF MINOR PARTICIPANTS**

I have fully read this Agreement and fully understand its content. Furthermore, the significance of this release of liability and assumption of risk agreement has been EXPLAINED TO THE MINOR.

I certify that I have custody or am the legal guardian of said minor and that I and/or my minor child are physically able to participate in recreation activities. In the event I or said minor requires medical treatment while under the supervision of staff and/or agents, I authorize said staff to provide and/or authorize medical treatment. I expect staff to contact me immediately in the event emergency medical treatment is required for said minor, but this contact is not necessary to administer emergency aid. I will pay for all medical treatment which I or said minor may require. I hereby grant permission to include pictures and/or video of me and/or said minor, -*while participating in LGS recreation program,* for brochures or other publicity. *LGS Recreation and its photographer will only take photographs and videos in a public setting in which there is a reasonable expectation of privacy*. I understand I will not receive any compensation for use of such pictures or video.
This Waiver of Claims/Assumption of Risk/Consent applies to future participation in all programs of LGS by all signatories and minors on whose behalf it has been signed.

Signature of parent or guardian: _____Date: _____

Print parent/guardian name: _____

Received by:

Date:

# Authorization and Consent for Field Trips

I hereby grant permission for my child to participate in mini-field trips with the staff, representatives, and employees of the World of Discovery Preschool. I understand that these trips will only take place in, on, and around the Argonaut Elementary School campus. Places may include their library, their auditorium for assemblies, and areas about the campus or outer field for walks. I understand the adult/child ratio will be 6:1 on such trips.

Name of Child_____Date:_____

Name (Print) of Parent/ Guardian_____

Signature of Parent/Guardian_____

Director/Site Supervisor's signature_____

**Los Gatos-Saratoga Community Education & Recreation**
**World of Discovery Preschool**
**Admission Agreement 2020-21** ***updated 12/17/2019***

**Basic Services Offered:** World of Discovery Preschool provides a preschool program in a developmental play-based environment for children age 2 - 6 years. **Based on availability**, our year-round program offers Monday thru Friday care with a 2, 3, or 5 day option. Full time child care hours are 7:30am – 6:00pm. Preschool hours are 8:45am – 11:45am.

**Tuition**: WOD is a year-round preschool program and tuition is billed monthly. We do not pro-rate. Please refer to your registration packet for closure dates, the fee schedule, late payment fees, and returned check fees policy. Make up days for any missed school days due to illness or personal reasons are not offered. If school closure is Director initiated due to an emergency, a makeup class will be offered.

**Daily Register Compliance:** It is required that the person bringing in the child or picking the child up from the preschool sign the child in and/or out and note the time. A complete legal signature is required. Initials are not adequate. Repeated failure to sign in/out may result in a penalty. This is required by the California Department of Social Services.

**Pick-up:** A Late Fee of $25 will be charged for every 15 minutes or portion thereof after the pick-up time, according to your child's schedule. This fee is payable at pick-up. Two verbal reminders will be given before charging the fee.

**Withdrawal/Change of Enrollment Procedure:** Changes to a student's tuition plan must be processed prior to the cutoff date noted on the Billing Calendar. Tuition plan changes must be documented on a Change Form available at World of Discovery and submitted to the Preschool Director for processing, space permitting. A $15 fee is incurred for processing each change. Please see the Billing Calendar for specific change/cancellation cut off dates.

**Conditions for Termination:** World of Discovery Preschool may terminate this agreement if the child's behavior threatens the physical, mental health or well being of the other children or the school experiences are not meeting the child's mental or physical needs.

**Holidays/Closure Dates:** Please refer to the registration packet for the complete list of dates we will be closed. In some instances, a day camp may be offered at an additional fee.

**Right of the licensing agency:** Under California law, the California Department of Social Services shall have the right at any time 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 children or any staff member and for the examination of all records relating to the operation of the facility.

This **Admission Agreement Contract** may be changed or modified when necessary. Such modifications must be in writing, and signed and dated by parent(s)/guardian (s) and preschool director/site director at least 30 days in advance.

**I have received, read, understand and agree to follow all center policies and procedures listed in this agreement, the registration packet, and in the parent handbook**.

Parent/Guardian Signature_____Date_____

Site Supervisor/Director Signature _____Date_____