

TELEGRAPH HILL NEIGHBORHOOD CENTER

After School Academy 2011-2012

School-Age (K-5)

REGISTRATION AND RELEASE FORM

| | | | |
|--------------|-----|-------------------|----------------------|
| CHILD'S NAME | AGE | CHILD'S BIRTHDATE | GRADE (IN FALL 2011) |
|--------------|-----|-------------------|----------------------|

PERSON(S) RESPONSIBLE FOR CHILD:

| | | | | |
|---------------------|------------|------------|------------|--------|
| NAME & RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE | E-MAIL |
| NAME & RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE | E-MAIL |

| | | |
|--------------------------|------|----------|
| CHILD'S PRIMARY ADDRESS: | CITY | ZIP CODE |
|--------------------------|------|----------|

EMERGENCY PICK-UP CONTACTS (OTHER THAN THOSE LISTED ABOVE)

Is this person authorized to pick your child up from Tel-Hi?

| | | | |
|---------------------|------------|------------|--|
| NAME & RELATIONSHIP | HOME PHONE | CELL PHONE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| NAME & RELATIONSHIP | HOME PHONE | CELL PHONE | <input type="checkbox"/> YES <input type="checkbox"/> NO |

ADDITIONAL PERSONS WHO MAY PICK UP MY CHILD FROM TEL-HI:

| | | |
|------|------------|------------|
| NAME | HOME PHONE | CELL PHONE |
| NAME | HOME PHONE | CELL PHONE |

MEDICAL INFORMATION AND CONSENT:

| | |
|--|------------------------|
| PHYSICIAN AND/OR DENTIST TO BE CALLED IN AN EMERGENCY | MEDICAL PLAN # |
| ADDRESS | PHONE NUMBER |
| IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN? | |
| CALL EMERGENCY HOSPITAL _____ | OTHER (EXPLAIN): _____ |
| PLEASE LIST ANY ALLERGIES OR SPECIAL MEDICAL CONDITIONS: | |

I give permission for my child to participate in all of the After School Academy 2011-2012 activities at the Telegraph Hill Neighborhood Center (Tel-Hi), including but not limited to field trips. I will assume full responsibility for my child and not hold Tel-Hi staff or volunteers responsible for any damages or accidents that may occur. In case of emergency, I give the staff of Tel-Hi permission to obtain medical help if needed.

Tel-Hi documents program activities which help assist us in obtaining funding to support Tel-Hi programs. In registering for this program, you give Tel-Hi permission to record your child's voice and/or picture for use in television, films, radio, website or printed media to further the mission of Tel-Hi. In signing this agreement I also acknowledge that I have received and agree to abide by the policies and procedures outlined in the ASA Family Handbook.

Parent 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 and telephone number of the local licensing office.

Licensing Office Name: Peninsula Regional Office
 Licensing Office Address: 801 Traeger Avenue, Suite 100, MS 29-24 San Bruno, CA 94066
 Licensing Office Telephone #: (650) 266-8843

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 (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.

Telegraph Hill Neighborhood Center
 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:

COMMUNITY CARE LICENSING DIVISION – Peninsula Regional Office
NAME _____

801 Traeger Avenue, Suite 100
ADDRESS _____

| | | |
|------------------|--------------|-----------------------|
| San Bruno | 94066 | (650) 266-8843 |
| CITY | ZIP 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:

| | |
|---|--|
| <u>Telegraph Hill Neighborhood Center</u> | <u>660 Lombard St. San Francisco, CA 94133</u> |
| (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) |
|--|-----------------|

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
()

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 |
|-------------------------|--------------------------------|--|

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

| | DATES | | DATES | | DATES |
|-----------------|-------|----------------|-------|-----------------------------|-------|
| Chicken Pox | | Diabetes | | Poliomyelitis | |
| Asthma | | Epilepsy | | Ten-Day Measles (Rubeola) | |
| Rheumatic Fever | | Whooping cough | | Three-Day Measles (Rubella) | |
| Hay Fever | | Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| | | | | |
|---------------------------------|-----|----|------------------------|---|
| DOES CHILD HAVE FREQUENT COLDS? | YES | NO | HOW MANY IN LAST YEAR? | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF |
|---------------------------------|-----|----|------------------------|---|

DAILY ROUTINES (*For infants and preschool-age children only)

| | | |
|---|----------------------------------|--|
| WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?* |
| DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?* |
| DIET PATTERN: (What does child usually eat for these meals?) | BREAKFAST | WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____ |
| | LUNCH | |
| | 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 NO | | YES 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: |
| YES NO | | YES 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: |
| YES NO | | YES 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 |
|--------------------|------|



The After School Academy

Release of Information

The After School Academy is interested working together with parents, teachers and school staff members in order to provide appropriate academic support for your child. Regular communication with your child's school enables us to provide homework assistance that is consistent with academic goals set forth by parents and teachers.

_____ Yes, I give permission for Tel-Hi staff to discuss my child's educational goals and progress with his/her teacher and school staff members.

_____ No, I do not give permission for Tel-Hi staff to discuss my child's educational goals and progress with his/her teacher or school staff members.

Student's Name: _____ Grade: _____

School: _____ Teacher: _____

Parent's Signature

Date