

LOS ALAMITOS CHILD DEVELOPMENT CENTER 2021/2022 CONTRACT

Child's Name _____ DOB _____

Parent's/Guardian's Name(s) _____ Site: _____

I understand and agree to the following:

1. I agree to pay monthly tuition fee of \$ _____ per month. Tuition is due on the 1st of each month. I understand that tuition is based upon the number of days school is in session per school year and that payment is divided into 10 equal payments. I understand that if the tuition is not received by the 10th of the month with the 10 month payment plan, a 10% late fee of the tuition amount will be assessed. If tuition is late 15 or more days, my child (ren) will be dropped from the program until all fees are paid.
2. I agree to pay a non refundable annual registration fee of \$ 175.
3. I understand that checks returned for insufficient funds will be assessed a \$30.00 fee and all future payments must be made to the CDC in the form of cash or postal money order. If the amount is not paid in full, the CDC will turn over the dishonored check and all other available information relating to this to the District Attorney's Office for potential criminal prosecution.
4. I understand that refunds of tuition will not be made for illness or absence. I understand that if I withdraw my child or request a change of program, written notice must be given to the director two weeks prior to the withdrawal or change. Upon withdrawal from the program, I am required to pay the amount due to the CDC from the number of days my child was enrolled based upon the daily rate.
5. I agree to maintain the sign in/sign out sheet on a daily basis with a legible signature each day my child is in attendance at the CDC.
6. The preschool closes daily at 11:30AM for the morning half day program; 3:00 PM for the afternoon half day program; 6:00pm for the full day programs. Any child not picked up on time will be charged a late fee of \$5.00 for the first minutes or portion thereof and an additional \$1.00 per minute for any additional time over 5 minutes. I understand that if my child is left at the center for a half hour beyond closing with no parent contact, my child will be placed in the care of the local police or sheriff. I understand that after three late pickups, my child could be terminated from the CDC program.
7. I have read and understand the CDC vaccination/Immunization Policy _____.
Parent initial
8. I give consent for my child to receive free health screening (ages/stages, hearing, vision, dental, height, weight) by the School Readiness Nurse during the school year.
Parent initial
The information from the screening may be shared with your child's lead teacher.
Parent initial
9. If a medical need arises, the program staff will contact me first and I will arrange to have my child picked up within 30 minutes. If I cannot be reached, I agree that the staff will contact an authorized adult on my child's emergency card to pick up my child. If the medical need is such that immediate and/or emergency medical attention is needed, I agree that program staff may contact the local paramedics and I will be responsible for any medical expenses incurred. .
Parent initial
10. I understand that the Los Alamitos Child Development Center Parent Handbook is available for me to read on the CDC website. I have read the handbook and agree to abide by the policies and procedures as stated. I fully realize that failure to comply with this agreement or the stated policies within the handbook may result in termination from the CDC program.
Parent initial
11. I understand that when the behavior of my child is disruptive to the program and prevents the program from being beneficial to him/her or to others, the child may be asked to be picked up within 30 minutes. If the behavior continues to disrupt the program, there will be a mandatory conference and possible termination from the program.
12. I understand that all enrollment forms must be completed in full prior to my child can be enrolled in the CDC program.

Date _____ Parent/Guardian _____
(Signature)



Los Alamitos Child Development Center

Vaccination/Immunization Policy

The Los Alamitos Child Development Center will not enroll children unconditionally without proof of immunization records as stated under SB277, The California School Immunization Law. Every child's immunization records will be reviewed and approved by the school readiness nurse before entry into the classroom. If incomplete vaccinations or records are submitted, your child's enrollment will be delayed until satisfied under the California School Immunization Law.

Section 120338 of the Health and Safety Code reads:

Effective January, 2020, notwithstanding Sections CA H&S Code 120325 and 120335, any immunizations deemed appropriate by the department pursuant to paragraph (11) of subdivision (a) of Section 120325 or paragraph (11) of subdivision (b) of Section 120335, may be mandated before a pupil's first admission to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, and only exemptions for specific medical reasons for each vaccination as indicated under SB276 and HSC 120370 are allowed and must be provided in writing by your child's MD or DO who has completed your child's annual physical.

California Health and Safety Code, Sections 120325-120375

Under these statutes, children in California are required to receive certain immunizations in order to attend public and private elementary and secondary schools, child care centers, family day care homes, nursery schools, day nurseries, and developmental centers (pre-kindergarten facilities). Schools, and pre-kindergarten facilities are required to enforce immunization requirements, maintain immunization records of all children enrolled, and submit reports.

California Code of Regulations Title 17 Division 1, Chapter 4, Subchapter 8

These regulations specify California school immunization requirements and provide additional clarifications of the law. Also available at www.oal.ca.gov.

I (parent/guardian), _____ have read, understand and will comply with the California School Immunization Law. I further understand that if my child is on a catch up schedule for immunizations and that schedule is not followed, my child may be excluded from the classroom until compliant under the California School Immunization Law. Failure to comply may result in your child being dis-enrolled from the CDC preschool program.

Child's Name: _____

DOB: _____

Parent/Guardian Signature

Date

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					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

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

DATE OF ADMISSION

LAST DATE OF ENROLLMENT

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
<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	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	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

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

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

Los Alamitos Child Development Cent & 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

()

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:

California Department of Social Services

NAME

Community Care Licensing Division/Orange County Child Care

ADDRESS

750 The City Drive Suite 250

CITY

Orange

ZIP CODE

92868

AREA CODE/TELEPHONE NUMBER

(714) 703-2808

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)

Los Alamitos Child Development Center

(PRINT THE ADDRESS OF THE FACILITY)

10293 Bloomfield Street, Los Alamitos, CA 90720

(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: California DHSS, Community Care Licensing Division Orange Co.

Licensing Office Address: 250 The City Drive, Orange, CA 92868

Licensing Office Telephone #: (714) 703-2808

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.

Los Alamitos Child Development 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

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)

Los Alamitos Child Development Center
(NAME OF CHILD CARE CENTER/SCHOOL) . 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:

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)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)		/ /	/ /			
HIB MENINGITIS	(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

LOS ALAMITOS UNIFIED SCHOOL DISTRICT
Enrollment Survey for New Students

Legal Name of Student _____
Last First Middle Birth Date Age

School Grade Previous School, City, State, and District (if known)

Several reports to state, federal, and local governments require information regarding home language (ED Code 62002), parent education and primary ethnicity. Please assist us by providing the information requested below.

HOME LANGUAGE

1. Which language did your child learn when he/she began to talk? _____
2. What language does your child most frequently speak at home? _____
3. What language do you use most frequently to speak to your child? _____
4. What language is most often spoken by the adults at home? _____

PARENT/GUARDIAN EDUCATION

In order to provide the California Department of Education (CDE) with accurate "similar school characteristics," please **circle** the highest level of education achieved in your immediate family:

not a high school graduate high school graduate some college/AA degree college graduate graduate school/post graduate training

MILITARY CONNECTED FAMILIES

In an effort to provide resources and support to military connected students and their families, please complete the following information:

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Military Branch: _____ Military Branch: _____

Current Status

ACTIVE DUTY-DEPLOYED RESERVE
ACTIVE DUTY-FULLTIME RETIRED
NATIONAL GUARD VETERAN

Current Status

ACTIVE DUTY-DEPLOYED RESERVE
ACTIVE DUTY-FULLTIME RETIRED
NATIONAL GUARD VETERAN

PRIMARY ETHNICITY – please complete both sections of ethnicity and race

Ethnicity: Is this student Hispanic or Latino? (Select only one)
No, not Hispanic or Latino Yes, Hispanic or Latino

Race: Please continue to answer the following by marking one or more of the boxes to indicate your student's race.

____ African American (not Hispanic)	____ Asian (Asian Indian)	____ Pacific Islander (Hawaiian)
____ American Indian/Alaskan Native	____ Asian (Laotian)	____ Pacific Islander (Guamanian)
____ Asian (Chinese)	____ Asian (Cambodian)	____ Pacific Islander (Samoan)
____ Asian (Japanese)	____ Asian (Other)	____ Pacific Islander (Tahitian)
____ Asian (Korean)	____ Filipino	____ Pacific Islander (Other)
____ Asian (Vietnamese)	____ Hmong	____ Caucasian/White

Date

Parent/Guardian Signature

Supplemental Preschool Enrollment Questionnaire

Child's Name: _____ Preschool site: _____ DOB: _____

Medical Needs

1. Known Allergies _____
 - a. Life threatening yes ☒ Epi-Pen yes ☒ Benadryl yes ☒ Inhaler yes ☒
2. Diagnosed medical problems: (Check yes if applicable)
 - a. Asthma yes ☒ Inhaler at school yes ☒
 - b. Diabetes yes ☒ Insulin at school yes ☒
 - c. Seizure disorder yes ☒ Diastat at school yes ☒
 - d. Frequent ear infections yes ☒ Ear tubes yes ☒
 - e. Known hearing loss yes ☒ Wears glasses yes ☒
 - f. ADHD/ADD yes ☒ Medication at school yes ☒
 - g. Autism yes ☒ ABA therapy yes ☒
 - h. Lactose intolerance yes ☒ Substitute soy milk yes ☒
3. Other health problems _____
4. Medications _____ Given at school yes—no
5. Surgeries _____
6. Physical limitations/Activity restrictions _____
7. Date of last dental visit _____
8. Date of last eye exam _____

Developmental Needs

1. Is your child fully potty trained? yes—no
2. Do you have any concerns regarding your child's social-emotional development yes—no
3. Do you have any concerns regarding your child's behavior (tantrums, etc.) yes—no
4. Does your child have any special needs?
 - a. Speech delay yes ☒
 - i. Receiving speech therapy --regional center/school district/private
 - b. Physical delay yes ☒
 - i. Receiving physical therapy or occupational therapy yes ☒
 - c. Developmental delay yes ☒
 - i. Regional center services _____
 - ii. School district services _____
 - iii. Please circle any that apply: IEP IFSP 504 plan Private therapy/services
5. Additional developmental information _____

I agree that this information is current and accurate. I am willing to provide the CDC office with verification of my child's medical/developmental needs that will assist in providing accommodations for my child. Should needs arise this year beyond what is stated, I agree to provide documentation to the CDC office and my child's teacher notifying them of additional medical or developmental needs. Please see the Parent Handbook at www.losal.org for further details.

Completed by: _____ Relationship: _____ Date: _____

PEDS RESPONSE FORM

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

1. Please list any concerns about your child's learning, development, and behavior.

2. Do you have any concerns about how your child talks and makes speech sounds?

Check one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

Check one: No Yes A little COMMENTS:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Check one: No Yes A little COMMENTS:

5. Do you have any concerns about how your child uses his or her arms and legs?

Check one: No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

Check one: No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

Check one: No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Check one: No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

Check one: No Yes A little COMMENTS:

10. Please list any other concerns.

Los Alamitos Child Development Center & State Preschool

Permission Sheet

Field Trip

I give permission for my child _____ to participate in the Los Alamitos Child Development Center/State Preschool field trips during his/her enrollment in the program.

Signature of Parent/Guardian

Date

Bus Transportation for Field Trips

I give permission for my child _____ to ride the district school bus on field trips to and from the Los Alamitos Child Development Center/State Preschool during his/her enrollment in the program.

Signature of Parent/Guardian

Date

Photo Release

I give permission for media use of photographs of my child in connection with the Los Alamitos Child Development Center/State Preschool activities.

YES _____

NO _____

Signature of Parent/Guardian

Date

Parent Directory

I would like to be included in the Los Alamitos Child Development Center/State Preschool Parent Directory with the following information.

Name	Yes	No
Address	Yes	No
Telephone #	Yes	No
Email	Yes	No

Signature of Parent/Guardian

Date