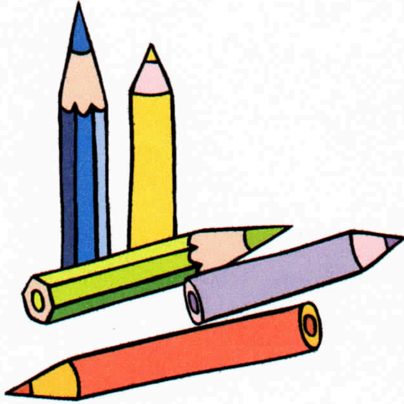
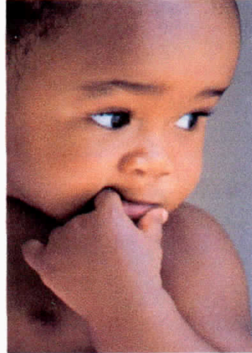
"Knowledge is to the mind what light is to the eye"





Little Angels Daycare

15609 Harvest Ave.
Granada Hills, CA 91344

Tel: (818) 366-1951
Fax: (818) 831-1064
Cell: (818) 730-4439

www.little-angels-granada-hills-day-care.com
www.daycarelittleangels.org

Little Angel Daycare

Enrollment Package

Please Complete, Sign & Return the following:

1. Emergency Information Enrollment Form
2. Identification and Emergency Information & Parent's Report
3. Physician's Report (to be completed & signed by a Physician)
4. Acknowledgement of Notification of Parents Rights & Personal Rights
5. Little Angeles Daycare Directory of Information & consent for Medical Treatment
6. Tuition Agreement

PLEASE attach the following copies:

1. Immunization card
2. Medical Insurance card
3. Copies of Drivers License of all the persons listed (authorized) to pick up your child from the daycare (for identification purposes ONLY)

ITEMS to bring: (Please mark your child's name on all)

1. Crib sheet, Blanket, Extra pair of clothes
2. Diapers/Pull-ups/Wipes, if you child is to be potty trained
3. Bottles/Sippy cup etc.

Little Angel Daycare

Emergency Information

Child's Name:
____

Home Phone #:
____

Mother's Name:
____

Mother's Cell: ______________________________ Pager:
____

Mother's Work Address:
____

____ Work Tel:
____

Father's Name:
____

Father's Cell: ______________________________ Pager:
____

Father's Work Address:
____

____ Work Tel:
____

Nearest Relative's Name:
____

Phone: ______________________ Cell: _________________ Pager:
____

Nearest Relative's Address:
____

____
______

Other Emergency Contact: Name:

Physician's Name: ______________________________ Tel:

____

Address:

____

Medical Insurance:____________________________Group/ID#:

____

Dentist's Name:______________________________Tel:

____

Anything special about the child that school should know:____________________

____

______

Medical Allergies:

____

Food Allergies:

____

Parent Signature:___________________________Date:

____

Please enclose a copy of the medical information card.

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVI
COMMUNITY CARE LICENS

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	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

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?

BREAKFAST __________

LUNCH __________

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

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERV
COMMUNITY CARE LICENSING DIVI

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 NAME LAST MIDDLE FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER STREET CITY STATE ZIP | HOME TELEPHONE ( )

MOTHER'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

*E-MAIL ADDRESS:____________________

IGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE | DATE

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

ATE OF ADMISSION | DATE LEFT

AFFIDAVIT REGARDING LIABILITY INSURANCE FOR FAMILY CHILD CARE HOME

SECTION A:

I/We, the parent(s)/guardian(s) of______________________________,
(Child's Name)

acknowledge that______________________________,
(Licensee'sName)

the licensee of ______________________________,
(Name of Family Child Care Home)

has informed me/us that this facility does not carry liability insurance or a bond in accordance with standards established by Family Child Care statute.

SECTION B: To be completed only if licensee does not own premises or the licensee is a member of a condominium or Homeowner's Association.

I/We, the parent(s)/guardian(s) of ______________________________,
(Child's Name)

acknowledge that______________________________,
(Licensee's Name)

the licensee of______________________________.
(Name of Family Child Care Home)

has informed me/us that she/he does not own the premises or is a member of a condominium or Homeowner's Association, and the liability insurance, if any, of the owner/Homeowners' Association may not provide coverage for losses arising out of, or in connection with, the operation of the family child care home, except to the extent that the losses are caused by, or result from, an action or omission by the owner/Homeowners' Association, for which the owner/Homeowners' Association would otherwise be liable under the law.

______________________________ ________________
Signature of Parent(s)/Guardian(s) Date

NOTE: The law requires Family Child Care providers to carry liability insurance or bond in the amount of $300,000 annually or to maintain this signed statement in the facility file. Lack of a bond or insurance does not effect the right of parents to bring legal action against the facility.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERV.

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 WHATEVER
NAME

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
( )

LIC 627 (5/01) (CONFIDENTIAL)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

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

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FACILITY NAME

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______________________ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

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
( )

IC 627 (5 01) (CONFIDENTIAL)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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), born ______________________ (BIRTH DATE) is being studied for readiness to enter

______________________________ (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:

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/DTaP/DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
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 ______________________

"Knowledge is to the mind what Light is to the eyes"

Dear Parents:

The welfare and safety of children is our paramount concern. Therefore, in addition to Pre-Admission Health Evaluation Form please inform us if any history or occurrences of the following medical conditions apply to your child:

1) **Seizures** ◊ **Yes** ◊ **No**

Condition: A sudden attack, spasm or convulsion.

2) **Epilepsy** ◊ **Yes** ◊ **No**

Condition: A neurological disorder characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.

3) **Fits** ◊ **Yes** ◊ **No**

Condition: A sudden and acute attack or manifestation of a disease.

4) **Convulsions** ◊ **Yes** ◊ **No**

Condition: A violent involuntary contraction of a muscle or muscles.

5) **Tremors** ◊ **Yes** ◊ **No**

Condition: Involuntary shaking of body or limbs.

6) **Paroxysm** ◊ **Yes** ◊ **No**

Condition: A sudden, violent outburst of action or emotions

6) **Any Other Abnormal Condition or Abnormalities** ◊ **Yes** ◊ **No**

Explain:____

Failure to disclose any of the above information may result in improper initial diagnosis endangering child's life or may cause serious injuries. In case of non-disclosure of this vital information Laghari Daycare will not be held responsible of any outcome produced by the above medical conditions.

____________________________ ______________

Parent/Parents Signature Date

DEAR PARENTS ____________________,

DATE:__________

WOULD YOU KINDLY GET THE FOLLOWING FOR YOUR CHILD:

________ **DIAPERS**

________ **WIPES**

________ **BABY OIL**

________ **POWDER**

________ **RASH CREAM**

________ **CEREAL**

________ **MILK**

________ **SNACK**

________ **LOTION**

________ **BABY WASH**

________ **SIPPY CUPS**

________ **BOTTLES**

________ **BLANKETS**

________ **EXTRA CLOTHES**

________ **OTHER**

________ **OTHER**

NOTES: