Welcome!

Attached is your enrollment packet and family information.

In developing this packet we have attempted to give you all the information and resources available to assist you in making your child’s transition to early childhood education a pleasant and rewarding one. All forms need to be completed, returned to the office with your nonrefundable enrollment fee, and audited by the Enrollment Coordinator before your child’s first day of enrollment. You have within thirty (30) days after the first day to turn in the Physician’s Report.

Our mission is to provide a high quality early childhood program for the children of University of California, San Diego students, staff and faculty through an enriched diverse environment. Our program cannot succeed without the support of interested parents and we value your input and experience. We encourage participation!

If you have any questions or concerns during your child’s enrollment, feel free to contact us. We will do our best to address your concerns and meet your family’s needs. We hope your family’s experience here is a pleasant and enriching one.

KATHRYN OWEN
Director
Dear Families,

We would like to inform you that work on the Mesa Child Development Center expansion will begin on August 10, 2015. As part of the expansion, two existing, nearby buildings will be renovated to create three classrooms, kitchen areas, a staff area, a nap/sick area and restrooms. There will also be site improvements including paving for walkways, outdoor play yards, new landscaping, lighting and installation of new play structures and fencing.

We are very excited about this project. Once completed, the expansion will make it possible to adopt aspects of the Reggio Emilia approach to learning in support of our hands-on, child-driven philosophy. It will also enable us to provide high-quality child care for more UC San Diego families.

Construction is expected to be completed in April 2016. During this time, every effort will be made to ensure the well-being and safety of the children. For example:

- All contractors must adhere to state and federal laws regarding safety as well as dust, noise, etc.
- A UC San Diego building inspector will be onsite daily to ensure all laws and regulations are being met.
- The UC San Diego Occupational Health and Hygiene Division can also provide additional monitoring services at the request of the center.
- Contractors can work between the hours of 7am-7pm, but they must honor quiet time between 1-3pm so the children can rest.

We also plan to use the expansion as a learning opportunity for the children, teaching them about construction and the equipment, materials and work that are needed to build something.

We will continue to share timely information and updates with you via email and on our website at child.ucsd.edu. If, at any time, you have questions about the project and what’s happening at our center, please don’t hesitate to call me or one of our other administrative staff members.

Thank you for your attention and support.

Kathryn

---

Kathryn J. Owen, MS, EC-SEBRIS
Director, Early Care and Education | University of California, San Diego
9500 Gilman Drive #0962, La Jolla, CA 92093-0962
P: (858) 246-0913 | F: (858) 246-0921 | E: kjoyen@ucsd.edu
<table>
<thead>
<tr>
<th>Item Description</th>
<th>Retain/To Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification and Emergency Information - Child Care Centers (LIC 700)</td>
<td>Retain</td>
</tr>
<tr>
<td>Emergency &amp; Medical Data (2 pages)</td>
<td>Retain</td>
</tr>
<tr>
<td>ECEC/MCDC Emergency Contact Information/Transport in Emergency Situation</td>
<td>Retain</td>
</tr>
<tr>
<td>Child’s Preadmission Health History – Parents’ Report (LIC 702)</td>
<td>Retain</td>
</tr>
<tr>
<td>Physician’s Report - Child’s Pre-Admission Health Evaluation (LIC 701)</td>
<td>Retain</td>
</tr>
<tr>
<td>Parent’s Guide to Immunization Requirements Immunization Clinic Schedules</td>
<td>To Family</td>
</tr>
<tr>
<td>Consent for Emergency Medical Treatment (LIC 827)</td>
<td>Retain</td>
</tr>
<tr>
<td>Parent Consent for Administration of Medications and Medication Chart (LIC 9221)</td>
<td>Retain (if applicable)</td>
</tr>
<tr>
<td>Written statement from family exempting child from medical assessment, immunizations, and treatment because of adherence to a religious faith that practices healing by prayer or other spiritual means; or physician’s statement that immunization is not indicated.</td>
<td>Retain (if applicable)</td>
</tr>
<tr>
<td>California School Immunization Records for non-school-age children (“blue cards”, PM 286)</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Family Handbook Acknowledgement of Receipt Admission/Enrolment Agreement (Contract of Membership)</td>
<td>Retain</td>
</tr>
<tr>
<td>Tuition Agreement &amp; Acknowledgement – Payment of $60.00 enrollment fee 30-Day Withdrawal Notice &amp; Acknowledgement</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Emergency Management Plan &amp; Acknowledgement of Receipt</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Notification of Parents’ Rights Acknowledgement of Receipt (LIC 995)</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Uniform Complaint Procedures and Acknowledgement of Receipt</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Caregiver Background Check Process (LIC 995F)</td>
<td>To Family</td>
</tr>
<tr>
<td>Acknowledgement of Receipt of Personal Rights (LIC 613A)</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Child Abuse Prevention Pamphlet</td>
<td>To Family</td>
</tr>
<tr>
<td>Acknowledgement of Receipt of Child Abuse Prevention Pamphlet</td>
<td>Retain</td>
</tr>
<tr>
<td>Parent/Guardian Affiliation &amp; Invoicing Information</td>
<td>Retain</td>
</tr>
<tr>
<td>Child Care Food Program Enrollment Application (CNFDD 3101)</td>
<td>Retain</td>
</tr>
<tr>
<td>Meal Benefit Form 2015</td>
<td>Retain</td>
</tr>
<tr>
<td>Your Child’s Comfort List</td>
<td>To Family</td>
</tr>
<tr>
<td>Questionnaire About Your Child</td>
<td>Retain</td>
</tr>
<tr>
<td>Family’s Infant Diapering/Tollling/Feeding Procedures</td>
<td>Retain</td>
</tr>
<tr>
<td>Medical Statement to Request Special Meals and/or Accommodations</td>
<td>Retain</td>
</tr>
<tr>
<td>Permission to Apply Sunscreen</td>
<td>Retain</td>
</tr>
<tr>
<td>Nebulizer Care Consent/Verification (LIC 9166)</td>
<td>Retain</td>
</tr>
<tr>
<td>Human Development Program/ECEC – Human Development Cooperation Agreement</td>
<td>Retain</td>
</tr>
<tr>
<td>Permission to Photograph &amp; Video</td>
<td>Retain</td>
</tr>
<tr>
<td>Request for Family Photograph</td>
<td>Retain</td>
</tr>
<tr>
<td>Acknowledgement of Receipt ECEC Holiday Calendar</td>
<td>Retain Original Copy to Family</td>
</tr>
<tr>
<td>Acknowledgement of Receipt 5 Week Menu Sample &amp; Food Program Participation and Permission to Subscribe to UCSD daycare-1 ListServ</td>
<td>Retain</td>
</tr>
<tr>
<td>Additional Documentation to be retained in Child’s File</td>
<td></td>
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<tr>
<td>Documentation of unusual behavior or signs of illness</td>
<td></td>
</tr>
<tr>
<td>Unusual Incident/Injury Report (LIC 624)</td>
<td></td>
</tr>
</tbody>
</table>

Note: All licensing forms can be downloaded from the DSS web-site http://www.dss.caahwnet.gov/edsweb/On-lineFor_293.htm. Forms are located under “L”
IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES
To Be Completed by Parent or Authorized Representative

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST</th>
<th>MIDDLE</th>
<th>FIRST</th>
<th>SEX</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
</tbody>
</table>

| 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

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
<th>RELATIONSHIP</th>
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</thead>
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</tbody>
</table>

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>ADDRESS</th>
<th>MEDICAL PLAN AND NUMBER</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTIST</td>
<td>ADDRESS</td>
<td>MEDICAL PLAN AND NUMBER</td>
<td>TELEPHONE</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
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</table>

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

LIC 700 (8/08) (CONFIDENTIAL)
# EMERGENCY & MEDICAL DATA

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST</th>
<th>MIDDLE</th>
<th>FIRST</th>
<th>BIRTHDATE</th>
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</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
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<tr>
<td>FATHER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
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<tr>
<td>HOME EMAIL ADDRESS</td>
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<td>HOME ADDRESS</td>
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<td>STREET</td>
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<tr>
<td>FATHER'S EMPLOYER</td>
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<td>ADDRESS</td>
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</tr>
<tr>
<td>MOTHER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
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<td>HOME EMAIL ADDRESS</td>
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<td>HOME ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
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<td>MOTHER'S EMPLOYER</td>
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<td>ADDRESS</td>
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<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
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<tr>
<td>RESPONSIBLE GUARDIAN'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
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</tbody>
</table>

**A. I authorize the following ADDITIONAL PERSON to be called IN AN EMERGENCY or other situation requiring removal of my child from the Center:**

<table>
<thead>
<tr>
<th>NAME</th>
<th>Home #</th>
<th>Business #</th>
<th>RELATIONSHIP/MOTHER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**B. MEDICAL AUTHORIZATION**

In case of fever and accompanying discomfort, I authorize the staff of the Early Childhood Education Center to administer Tylenol to my child in the appropriate dosage until I or an authorized person from above can be located to take my child from the Center. This authorization is valid as long as my child is enrolled at the Center.
C. CONSENT FOR ACCESS TO PHYSICIAN'S RECORD

Name of Physician: 
Telephone #: 

I authorize the following individuals to exchange health information regarding my above mentioned child. This includes access to information from my child’s medical records that are pertinent to my child’s health and safety. I understand that information in my child’s record will not be released to individuals not listed below without my specific written consent.

My child’s caregiver: UCSD Early Childhood Education Center

Other Staff/Consultant: 

Address: 
9500 Gilman Drive, Mail Code 0962
La Jolla, CA 92039-0962

Telephone: 
(858) 534-2768

D. MEDICAL INFORMATION AND RELEASE CARD

Allergies? 
Epilepsy? 
Blackouts? 
Severe bleeding? 

I, the undersigned parent of the above named minor, do hereby consent to an x-ray, examination, anesthesia, medical or surgical diagnosis or treatment and hospital services rendered to said minor under general or specific instructions of the above named physician or the doctor on duty at the emergency room at Thornton Hospital whether such treatment is rendered at the office of said physician or at a licensed hospital. It is understood that the consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage persons at the UCSD Early Childhood Education Center into whose custody the minor is entrusted and said physician to exercise their best judgment as to necessary diagnosis or treatment. Consent is also given to those persons into whose custody the minor is entrusted to administer emergency first aid.

I AUTHORIZE CONSENT TO THE ABOVE SECTIONS A, B, C, D:

Signature of Parent/Legal Guardian: 
Date: 

PLEASE FILL OUT ALL 3 COPIES WITH ORIGINAL SIGNATURES ON EACH PAGE
ECEC/MCDC Emergency Contact Information
(Please fill out all fields)

Child’s Name: __________________________ D.O.B. __________________________

Legal Guardian #1 Name:______________________________

Telephone Numbers: Home________________ Work:____________________

Legal Guardian #2 Name:______________________________

Telephone Numbers: Home________________ Work:____________________

Emergency Contacts (to whom child may be released if legal guardian is unavailable)

Name #1______________________________

Telephone Numbers: Home________________ Work:____________________

Name #2______________________________

Telephone Numbers: Home________________ Work:____________________

Child’s Usual Source of Medical Care

Name:______________________________

Address:______________________________

Telephone Number:____________________

Child’s Health Insurance Plan:______________ ID#:____________________

Subscriber’s Name(on insurance card)______________________________

Special Conditions, Disabilities, Allergies, or Medical Information for Emergencies:

________________________________________

Transport Arrangement in an Emergency Situation

Ambulance service:__________________ Child will be taken to:__________________

Parent/Legal Guardian Consent and Agreement for Emergencies:
As a parent/legal guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Date:____________ Parent/Legal Guardian’s Signature #1____________________

Date:____________ Parent/Legal Guardian’s Signature #2____________________

California Child Care Health Program

UCSD: ECEC/MCDC 12/14/2010
**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?**

**HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?**

**DATE OF LAST PHYSICAL/MEDICAL EXAMINATION**

**DEVELOPMENTAL HISTORY** *(For infants and preschool-age children only)*

<table>
<thead>
<tr>
<th>VAKED AT</th>
<th>MONTHS</th>
<th>BEGAN TALKING AT</th>
<th>MONTHS</th>
<th>TOILET TRAINING STARTED AT</th>
<th>MONTHS</th>
</tr>
</thead>
</table>

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

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

*Specify any other serious or severe illnesses or accidents*

**DOES CHILD HAVE FEVER/COLD?**

**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?**

**DAYS CHILD SLEEPS DURING THE DAY**

**WHEN?**

**HOW LONG?**

**BREAKFAST**

**WHAT ARE USUAL EATING HOURS?**

**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 MEDICATIONS?**

**YES**

**NO**

**IF YES, WHAT KIND AND ANY SIDE EFFECTS?**

**DOES CHILD USE ANY SPECIAL DEVICES?**

**YES**

**NO**

**IF YES, WHAT KIND?**

**DOES CHILD USE ANY SPECIAL DEVICES AT HOME?**

**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/FEAR/NEEDS? (EXPLAIN)**

**WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?**

**REASON FOR REQUESTING DAY CARE PLACEMENT**

**PARENT’S SIGNATURE**

**DATE**

**LAD 702 (REV 08) (CONFIDENTIAL)**
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 ____________________________

is being studied for readiness to enter

UCSD Early Childhood and Education Center ____________________________.

This Child Care Center/School provides a program which extends from ______:____

a.m./p.m. to 5:00 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.)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLIO (OPV OR IPV)</td>
<td>/</td>
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</tr>
<tr>
<td>DTP/DTaP/DTaPd (Diphtheria, Tetanus and [acellular] Pertussis OR Tetanus and Diphtheria only)</td>
<td>/</td>
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</tr>
<tr>
<td>MMR (Measles, Mumps, and Rubella)</td>
<td>/</td>
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</tr>
<tr>
<td>(Required for child care only) (Haemophilus b)</td>
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<td>/</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>/</td>
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<td>/</td>
</tr>
<tr>
<td>VARICELLA (Chickenpox)</td>
<td>/</td>
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</tr>
</tbody>
</table>

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.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.
# Parents' Guide to Immunizations

**Required for Child Care**

**Requirements by Age at Entry and Later** (Follow-up is required at every age checkpoint after entry.)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>2–3 Months</th>
<th>4–5 Months</th>
<th>6–14 Months</th>
<th>15–17 Months</th>
<th>18 Months–5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio (OPV or IPV)</td>
<td>1 dose</td>
<td>2 doses</td>
<td>2 doses</td>
<td>3 doses</td>
<td>3 doses</td>
</tr>
<tr>
<td>Diphtheria, Tetanus, and Pertussis (DTaP or DTP)</td>
<td>1 dose</td>
<td>2 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td>4 doses</td>
</tr>
<tr>
<td>Measles, Mumps, and Rubella (MMR)</td>
<td></td>
<td></td>
<td>1 dose on or after the 1st birthday</td>
<td>1 dose on or after the 1st birthday</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>1 dose</td>
<td>2 doses</td>
<td>2 doses</td>
<td>1 dose on or after the 1st birthday</td>
<td>1 dose on or after the 1st birthday (only required for children less than 4 years, 6 months.)</td>
</tr>
<tr>
<td>Hepatitis B (Hep B or HBV)</td>
<td>1 dose</td>
<td>2 doses</td>
<td>2 doses</td>
<td>2 doses</td>
<td>3 doses</td>
</tr>
<tr>
<td>Varicella (chickenpox, VAR or VZV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
</tbody>
</table>

**WHY YOUR CHILD NEEDS SHOTS:**

The California School Immunization Law requires that children be up-to-date on their immunizations (shots) to attend a child care, day nursery, nursery school, family day care home, or development center.

Diseases like measles and whooping cough (pertussis) spread quickly, so children need to be protected before they enter. Staff will check your child's Immunization Records before they start and later, at ages listed above.

**WHAT YOU WILL NEED AT REGISTRATION:**

Bring your child’s Immunization Record. The Immunization Record must show the date for each required shot above. If you do not have an Immunization Record, or your child has not received all required shots, call your doctor now for an appointment.

If a licensed physician determines a vaccine should not be given to your child because of medical reasons, submit a written statement from the physician for a medical exemption for the missing shot(s).

Until 2016, if a vaccine is contrary to your personal beliefs, you may submit form CDPH 8262 for the missing shot(s). The form must include the signatures of both a parent and an authorized health care practitioner. For details, see: ShotsForSchool.org/ laws/faspsphpa.

You must also submit an immunization record for all required shots not exempted.

Questions? Visit ShotsForSchool.org or contact your local health department (bit.do/immunization).
### County of San Diego Public Health Centers

**Immunization Clinic Schedules**

The clinic hours below are subject to change.

A limited number of people will be seen each day.

Online appointments available at some locations. Visit: [https://onlineappts.hhsha-sdcounty.org/](https://onlineappts.hhsha-sdcounty.org/)

### SAN DIEGO CITY

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Days</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Heights</td>
<td>Central Region Public Health Center 5202 University Ave., 92105</td>
<td>Mon.</td>
<td>8:30-11 a.m. &amp; 1-4 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs.</td>
<td>8:30-11 a.m. &amp; 1-4 p.m.</td>
</tr>
<tr>
<td>Southeast City</td>
<td>VIP Trailer 3177A Oceanview Blvd., 92113</td>
<td>Mon.-Fri.</td>
<td>8-11 a.m. &amp; 1-3 p.m.</td>
</tr>
</tbody>
</table>

### NORTHERN SAN DIEGO CITY

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Days</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kearny Mesa</td>
<td>North Central Public Health Center 5055 Ruffin Rd., 92123</td>
<td>Mon.-Fri.</td>
<td>8:30-11 a.m. &amp; 1-4 p.m.</td>
</tr>
<tr>
<td></td>
<td>Located at the North Central Regional Center</td>
<td>2nd Thurs.</td>
<td>1-4 p.m.</td>
</tr>
</tbody>
</table>

### SOUTH COUNTY

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Days</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chula Vista</td>
<td>South Region Public Health Center 690 Oxford St., 91911 Behind Walmart</td>
<td>Mon.-Wed. &amp; Fri Thurs.</td>
<td>8 a.m.-4 p.m. 8 a.m.-12 p.m.</td>
</tr>
</tbody>
</table>

### EAST COUNTY

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Days</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Cajon</td>
<td>East Region Public Health Center 367 N. Magnolia Ave., Ste. 101, 92020</td>
<td>Mon.-Wed. &amp; Fri Thurs.</td>
<td>8:30-11 a.m. &amp; 1-4 p.m. 1-4 p.m</td>
</tr>
</tbody>
</table>

### NORTH COUNTY

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Days</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escondido</td>
<td>North Inland Public Health Center 649 W. Mission Ave., Suite 2, 92025</td>
<td>Mon. &amp; Fri.</td>
<td>8-11 a.m. &amp; 1-4 p.m.</td>
</tr>
<tr>
<td>Fallbrook</td>
<td>Fallbrook Public Health Office 202 W. College Ave., 92028</td>
<td>2nd Mon. of the month &amp; (3rd &amp; 4th Tues. of the month by appt. only; call 760-967-4401)</td>
<td>11 a.m.-5 p.m.</td>
</tr>
<tr>
<td>Oceanside</td>
<td>North Coastal Public Health Center 104 S. Barnes St., 92054</td>
<td>Mon., Tues., Thurs. &amp; Fri Wed.</td>
<td>8 a.m.-4:30 p.m. 8-11 a.m.</td>
</tr>
<tr>
<td>Ramona</td>
<td>Ramona Public Health Office 1521 Main St., 92065</td>
<td>2nd Wed. of the month</td>
<td>1-3 p.m.</td>
</tr>
<tr>
<td>Rancho Peñasquitos</td>
<td>New Hope Church 10330 Carmel Mountain Rd., 92129</td>
<td>3rd Wed. of the month</td>
<td>8:30-11 a.m.</td>
</tr>
<tr>
<td>Solana Beach</td>
<td>Solana Beach Presbyterian Church 120 Stevens Ave., 92075</td>
<td>2nd Tues. of the month</td>
<td>1-5 p.m.</td>
</tr>
</tbody>
</table>

For information regarding TB skin testing, please call (619) 692-5565

For immunization information, please visit our website at [www.sdiz.org](http://www.sdiz.org) or call 211.
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

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

( ) ( )

LIC 027 (9/08) (CONFIDENTIAL)
PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: Regulation Section 101221 requires the following information be on file.

<table>
<thead>
<tr>
<th>CHILD CARE CENTER NAME:</th>
<th>LICENSE NUMBER:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

PARENT’S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSAGE</th>
</tr>
</thead>
</table>

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From ___________ to ___________ at ___________ daily while in attendance.

<table>
<thead>
<tr>
<th>BEGINNING DATE</th>
<th>ENDING DATE</th>
<th>TIME OF DAY</th>
</tr>
</thead>
</table>

PARENT’S SIGNATURE: ___________________________ DATE: ___________

MEDICATION CHART

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME GIVEN</th>
<th>STAFF SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Upon completion, return medicine to parent or destroy, and place form in child’s record.

<table>
<thead>
<tr>
<th>STAFF</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIC 0221 (8/03)
FAMILY HANDBOOK

ACKNOWLEDGEMENT OF RECEIPT
(To be retained in child’s file)

I have received the latest edition of the UCSD Early Childhood Education Center’s Family Handbook. I agree to review and familiarize myself with its contents, policies and procedures and be responsible for the information contained therein. If a discrepancy exists between the Handbook and any legal mandate, the legal mandate will take precedence.

______________________________  _______________
Signature                                  Date

ADMISSION/ENROLLMENT AGREEMENT
(Contract of Membership)

I have received the Family Handbook and have read and understand the Standing Rules of Order contained therein. As the parent/legal guardian of

______________________________
(Child’s Name)

I agree to comply with the Standing Rules of Order of the Association of University of California, San Diego Early Childhood Education Center Parents for as long as my child is enrolled. I also agree to:

✓ Adhere to current fee schedules and procedures.
✓ Participate in at least one fundraising event per year.
✓ Comply with the policies set forth in the Family Handbook.

I understand that failure to comply with the above may result in the termination of my child(ren)’s eligibility to attend the UCSD Early Childhood Education Center.

______________________________  _______________
Signature of Parent/Legal Guardian                                  Date

______________________________  _______________
Signature of Parent/Legal Guardian                                  Date
TUITION AGREEMENT & ACKNOWLEDGEMENT

This space opens on _______________________. Your billing will begin on this date.
Your child(ren) will be in classroom(s) _______________________________________.
Your monthly tuition fee will be $__________________. Please attach your check, made payable to the U. C. Regents, in the sum of $60.00 representing your non-refundable enrollment fee (not applicable for subsidized program).

I acknowledge that I have received a copy of this Tuition Agreement.

Signature _______________________________ Date ________________

30 DAY WITHDRAWAL NOTICE
(Intent to Remove Child)

ACKNOWLEDGEMENT
(To be retained in child’s file)

I hereby acknowledge that I have been advised that the Center requires that a signed and dated 30-Day Withdrawal Notice form be delivered to the ECEC Administrative Office indicating our intent to remove our child(ren) from the Center. This Notice is required so that the Center can remain in compliance with UCSD Audit Guidelines and also enables your child(ren)s classroom slots be filled by those on the Center’s Waitlists and thus avoid any loss of income to the Center. Administration Office staff can also provide a copy of this 30-Day Withdrawal Notice form for your convenience in complying with this Notice provision.

Signature _______________________________ Date ________________
30-DAY WITHDRAWAL NOTICE
(REQUIRED: Refer to Family Handbook)

I, ________________________________ parent/legal guardian
of ______________________________(child), do hereby give my official 30-
day notice of intent to withdraw my child from the UCSD Early Childhood Education
Center Room ___.

My child's last day will be _________________(date). I understand that my billing
will continue for one month from the date this 30-Day Withdrawal Notice is received and
acknowledged by the ECEC administrative staff, as indicated from signatures below.

Reason for Leaving:
________________________________________
________________________________________
________________________________________

My New Forwarding Address:
________________________________________
________________________________________

________________________
Signature (Parent/Legal Guardian)

**************************************************************************

I do hereby acknowledge receipt of this 30-Day Withdrawal Notice this _______day of
_______________ 20__.

________________________
Signature of ECEC Director/Business Manager/Authorized Representative

Please complete Exit Questionnaire on page 2 of this 30-Day Withdrawal Notice.
(Original to ECEC/Copy for parent/guardian/authorized representative)

(OVER)
EXIT QUESTIONNAIRE

What is your overall feeling of the ECEC?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What could we have done differently to better serve your needs?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Are there any areas in which you feel ECEC could improve (e.g. curriculum, administration, parent involvement, etc.)?

__________________________________________________________________________
__________________________________________________________________________

If you had the opportunity or need in the future, would you use the services ECEC provides?

  Yes □ No □

Please indicate why you would, or wouldn't use our services again.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Would you recommend our program to others?

  Yes □ No □

Your comments will help us to improve our program, please share both your compliments and concerns.~ Thank you
EMERGENCY MANAGEMENT PLAN

INTRODUCTION

This Plan has been written to prepare the UCSD Early Childhood Education Center (ECEC) for a major earthquake or other disaster, including fires, flooding, explosions, or violent individuals. In any type of emergency situation, you should attempt to implement as much of the plan as is relevant and useful.

All staff, volunteers, parents, and guests of the Center are expected to comply with the Plan. You should study this Plan so that you understand how it fits in with your personal emergency plan and with the campuswide emergency plan. Emergency drills are held regularly at the Center.

The priorities contained in UCSD’s campuswide emergency plan have been adopted by ECEC. Those priorities are:

1. Save Lives
2. Protect University Property
3. Restore Operations
4. Meet Community Needs

WHO DO I CALL?

You can call our cellular phone number at (619) 988-7890.

WHERE DO I PARK?

The Early Childhood Education Center will be evacuated to the field just East of the Center. Please park in the East lot of the apartment complex (see map attached).

(Do not park in front of the ECEC building as it is reserved for emergency vehicles.)

WHERE CAN I FIND MY CHILD?

Everyone will be evacuated to the field just East of the Center (see map attached). You can walk down the utility road from the parking lot to meet us. If this area is unsafe due to the nature of the emergency, our second site will be the parking lot on the South end of the ECEC complex that is provided for the Housing Office for the Mesa Residential Apartments.

If Regents Road or Miramar Road are not accessible to vehicular traffic you can park by Thornton Hospital and walk across the canyon (via the bicycle path) to meet your child(ren).
After an assessment team has declared the facility safe we will re-enter the building. In this case you may meet your child(ren) in his/her classroom. *(PLEASE MAKE SURE YOU SIGN YOUR CHILD OUT BEFORE YOU LEAVE.)*

**WHAT IF MY CHILD IS INJURED?**

All ECEC staff are trained in infant/child first aid/CPR. In the event of serious injury your child will be transported to Thornton Hospital.

**HOW WILL YOU CARE FOR MY CHILD?**

Our Center has enough supplies to care for the children and staff for 3 days. Our classroom supplies include: food, water, blankets, tents, diapers, toys, children’s books, porta-potties, first aid supplies, light sticks, flashlights, radios, batteries, and much more. Many other useful supplies, including food, water, blankets and tools are located in the main storage bin located in the park at the east end of the Center.
ACKNOWLEDGEMENT OF RECEIPT
(To be retained in child’s file)

By signature below I acknowledge that I have received a copy of the Emergency Management Plan.

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: Mission Valley Child Care Licensing

   Licensing Office Address: 7575 Metropolitan Dr. Suite 110, San Diego 92108

   Licensing Office Telephone #: 619-757-2200

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

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.

______________________________
UCSD Early Childhood Education 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
Department of Education
UNIFORM COMPLAINT PROCEDURES

It is the intent of the Early Childhood Education Center (ECEC) to fully comply with all applicable state and federal laws and regulations.

Individuals, agencies, organizations, students and interested third parties have the right to file a complaint regarding the ECEC program’s alleged violation of federal and/or state laws. This includes allegations of unlawful discrimination (Ed Code sections 200 and 220 and Government Code section 11135) in any program or activity funded directly by the State or receiving federal or state financial assistance.

Complaints must be signed and filed in writing with the State Department of Education.

Child Development Division
Complaint Coordinator
1430 N Street, Suite 3410
Sacramento, CA 95814

If the complainant is not satisfied with the final written decision of the California Department of Education, remedies may be available in federal or state court. The complainant should seek the advice of an attorney of his/her choosing in this event.

A complainant filing a written complaint alleging violations of prohibited discrimination may also pursue civil law remedies, including, but not limited to, injunctions, restraining orders, or other remedies or orders.

NOTE: This Acknowledgement must be kept in child’s file and a copy of the Procedure given to parent/legal guardian.
CAREGIVER BACKGROUND CHECK INFORMATION

The law requires that the Community Care Licensing Division check the criminal background of all adults who apply for a license to operate a community care facility. We also check the criminal background of all adults who want to work, reside in or have contact with clients being cared for in a community care facility.

What is a background check?

As part of the background check process you must be fingerprinted and tell whether you have ever been convicted of a crime other than a minor traffic violation. The Department of Justice and the FBI will check your fingerprints against their criminal record information. If you will have contact with children, your name will be checked against the Child Abuse Central Index registry. This is a listing of people who have been reported for suspected child abuse. If you have not been convicted of a crime and have no child abuse history, you will be given a “clearance.”

What if I have a criminal conviction?

If you were ever convicted of a crime, other than a minor traffic violation, even if it happened a long time ago, you cannot own, live or work (including some volunteers) in a facility unless we give you an “exemption.” If the Department of Justice notifies us that you were convicted of a crime, we will notify the facility operator that an exemption is needed. If you were convicted of a serious crime or if you are on supervised probation after being convicted of a crime, you probably won’t be given an exemption.

You do not qualify for a criminal record exemption if you have ever been convicted of a serious crime such as robbery, sexual battery, child abuse, elder or dependent adult abuse, rape, first degree burglary, arson, or kidnapping. These kinds of crimes are nonexemptible and if you were convicted of one of them, by law you will never be allowed in a facility.

How do I get a criminal record exemption?

As part of the request for an exemption, the facility operator or you must send us convincing proof that you are of good character in spite of your conviction. We will review any information you submit as well as the number and type of crimes committed, how long ago the crime(s) happened, what kind of work you will be doing and whether you will be working with children, adults, or the elderly. If we find that you were not truthful in the information you submitted for your exemption, we will deny your exemption request. In most cases, if you are currently on supervised probation or on parole you will not be granted an exemption. If your exemption is denied, and you are married to or living with someone who is applying for a license and care will be provided in your home, his or her application will be denied because everyone who lives in the home must have a clearance or exemption. If a criminal record exemption is granted to you and you later move, or want to work in a different facility, your exemption will be re-evaluated based on your new role and our current laws, regulations, and policies. If you are arrested or convicted after an exemption is granted to you, your exemption may be cancelled. If you are married to or living with someone who is licensed, and care is provided in your home, the facility license may be suspended or revoked.

You are strongly encouraged to read the licensing criminal record exemption regulations to find out the amount of time that must pass following your conviction, before you can qualify for an exemption. Some convictions require longer periods of time following conviction than others. The regulations and other information can be found on our web site at www.cclld.ca.gov.

How long does the criminal record exemption process take to complete?

If you do not have a criminal record, a clearance is normally available in a few days. If an exemption is needed, it may take three months or longer to complete the process.

DISCLOSURE OF CRIMINAL RECORD EXEMPTION INFORMATION
UNDER THE CALIFORNIA PUBLIC RECORDS ACT

If you are granted a criminal record exemption, your name will be given out to the public, upon request. If you own a facility and you have staff, residents or volunteers who have a criminal record exemption, the name of your facility will be given out to the public, upon request.
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
Mission Valley Child Care Licensing

ADDRESS
7575 Metropolitan Dr. Suite 110

CITY
San Diego
ZIP CODE
92108
AREA CODE/TELEPHONE NUMBER
(619) 767-2200

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

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:

UCSD Early Childhood Education Center
9224 Regents Rd., La Jolla, CA 92037

(LIC 815A (8/09))
CHILD ABUSE PREVENTION

ACKNOWLEDGEMENT OF RECEIPT
(To be retained in child’s file)

By signature below I acknowledge that I have received a copy of the Child Abuse Prevention pamphlet, a guide to the understanding of child abuse.

Signature

Date
PARENT/GUARDIAN AFFILIATION & INVOICING INFORMATION
(To be retained in child's file)

For purposes of usage surveys and daytime contacts, please indicate the campus department and mail code or company with which you are affiliated.

<table>
<thead>
<tr>
<th>Mother is (Circle one):</th>
<th>Faculty</th>
<th>Staff</th>
<th>Student</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>□ Graduate □ Undergrad</td>
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<td>Department:</td>
<td>Mail Code:</td>
<td>Occupation:</td>
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<tr>
<th>Father is (Circle one)</th>
<th>Faculty</th>
<th>Staff</th>
<th>Student</th>
<th>Other</th>
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<td>□ Graduate □ Undergrad</td>
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<td>Department:</td>
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In order to simplify the task of billing the large number of people we serve, we are asking you to please complete the bottom portion of this page. If you are a UCSD affiliate, invoices must be in the name of the person affiliated with the University. If you are not a UCSD affiliate please fill in the information for the person who will be responsible for the tuition payments. Please inform us of any changes in your affiliation status, address or phone number and include your zip code and social security number. All of these items are required by the university's accounting office. Your cooperation is appreciated.

Full name of person to be invoiced:

Address (Number, Street, and Apartment)

City, State, Zip Code

Telephone Number (daytime)

Social Security Number

Email address
YOUR CHILD’S COMFORT LIST

To make your child’s first day of attendance at the Center an easy transition, we have prepared the following list of things to do or bring:

1. Bring a change of clothes labeled with your child’s name.

2. If your child is still wearing diapers you will need to bring disposable diapers and wipes.

3. If he/she is in the process of potty training, you will need to bring 3 sets of extra clothing including socks and an extra pair of shoes. (NO training or plastic pants, no dresses, belts, suspenders or snapped t-shirts). See Family Handbook for complete Toilet Learning Procedure.

4. If your child has a security object, you may want to consider bringing it, at least for the first week or so; however, it is our policy to discourage bringing “hype toys” (such as Power Rangers), expensive or breakable toys as the Center is not responsible for lost, broken or stolen toys. Please consult the lead teacher of your child’s program before leaving anything at the Center.

5. Please bring a blanket labeled with your child’s name for his/her use at nap time.

6. If your child is on medication, please bring the medication if it will need to be administered during the day. Make sure you sign the medication release form in your child’s classroom otherwise the Center’s staff is not authorized to administer it. A Physician’s note with specific instructions must accompany all medication explaining how it is to be administered (i.e. amount, time, etc.). All medications are required to be in their original containers and cannot be administered to siblings. See Family Handbook for complete policy.

7. Be sure to fill out the section on the Questionnaire About Your Child form that indicates any additional information that the teacher should know, especially relating to allergies.

8. If your child has any allergies or medical condition(s) that requires a special meal or accommodations, fill out the Medical Statement to Request Special Meals and/or Accommodations form; if your child does not require any meal accommodations, please indicate ‘not-applicable’, sign and return this form.

9. Before your child can start, the attached enrollment packet must be completed. Please pay special attention to the following items as they are often overlooked:
   (A) All immunizations must be up to date (see Parent’s Guide to Immunization Requirements)
   (B) All parents have the opportunity to talk with the Director before the child’s first day. You can call 246-0900 to schedule an appointment or phone conference.
   (C) All 3 copies of the Emergency & Medical data forms must have original signatures.
   (D) The non-refundable $60.00 enrollment fee is due at the time you turn in your child’s enrollment packet (not applicable for subsidized program).

10. The Center is open for business at 7:30 a.m. and requires that your child be picked up by 5:00 p.m. There is an After Hours Program (for children 18 months and older) that runs from 5:00 p.m. to 6:00 p.m. (by the clock in the classroom) and a fee of $7.00 per child is charged for use of that service. Families who do not pick up their child(ren) by 6:00 p.m. will be fined $10.00 for every fifteen minutes; therefore, there will be a $10.00 per child charge even if you are one minute late in picking up your child(ren). See Family Handbook.

If you have any questions about the curriculum, the lead teacher of your child’s program is _______________________ and the room number is ____________________. Please feel free to contact the office at (858) 246-0900 with any other questions you may have.
QUESTIONNAIRE ABOUT YOUR CHILD

State regulations require that a personal interview be conducted with parents. Parents have the right not to respond to questions.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Child’s Place of Birth</th>
<th>Birthdate</th>
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<tbody>
<tr>
<td>Names of other children in the family</td>
<td>Sex</td>
<td>Age</td>
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</table>

Languages spoken in the home

<table>
<thead>
<tr>
<th>Yes/No Questions</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you like your child to be called by his/her nickname?</td>
<td></td>
<td></td>
<td>If so, what is the name?</td>
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<tr>
<td>Has your child ever attended another preschool, Headstart, or day care center?</td>
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<td>If so, where?</td>
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<tr>
<td>Has your child learned to do the following things without help?</td>
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<tr>
<td>Take care of all/some toilet needs?</td>
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<tr>
<td>Speak clearly enough that strangers can understand?</td>
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<tr>
<td>Awaken self to go to the bathroom?</td>
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<tr>
<td>Take care of and replace own toys and equipment?</td>
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<tr>
<td>Respects rights and property of others?</td>
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<tr>
<td>Express self with words instead of physical force?</td>
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<tr>
<td>Any special circumstances surrounding pregnancy or birth?</td>
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<tr>
<td>Does a child have a close relationship with any relatives outside the home?</td>
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<td>If so, whom?</td>
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<tr>
<td>Are there any things your child really dislikes having done to him/her?</td>
<td></td>
<td></td>
<td>If so, what?</td>
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<tr>
<td>Are most of the child’s friends his/her own age, same sex?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes/No Questions</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
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<tr>
<td>Are there any holidays your child cannot take part in because of religious or family/cultural tradition?</td>
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<tr>
<td>Are there any family/cultural traditions and holidays you might like to share with the children at the Center?</td>
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<tr>
<td>What are the child’s responsibilities in the home (for example: such chores as feeding pets, emptying trash)?</td>
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<td>How do you feel a child should behave?</td>
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<td>What do you feel is the best thing about your child’s behavior at home?</td>
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<tr>
<td>What have you found is the best way to get your child to do what you want him/her to do?</td>
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<tr>
<td>What methods do you use to discipline your child?</td>
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<tr>
<td>What methods do you prefer at the Center?</td>
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<tr>
<td>How do you handle:</td>
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<tr>
<td>Aggression?</td>
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<tr>
<td>Punishment?</td>
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<tr>
<td>Toilet training?</td>
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<tr>
<td>Sex roles?</td>
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<tr>
<td>Curiosity about sex?</td>
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<tr>
<td>Going barefoot?</td>
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<tr>
<td>Racial concerns?</td>
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<td>When did your child begin playing with other children?</td>
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<td>Does your child like playing with a group of children, or just one or two?</td>
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<td>If your child has a choice, will he/she spend his/her free time alone or with friends?</td>
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<td>What is your child’s favorite activity?</td>
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<td>How does your child appear to feel about adults, children the same age, or younger children?</td>
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<td>What are some of your child’s skills (for example: singing, swimming)</td>
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<td>What would you like your child to get from this experience at the UCSD Early Childhood Education Center?</td>
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<tr>
<td>Are you interested in arranging group cooperative baby-sitting occasionally so that you could have free time of your own?</td>
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<tr>
<td>Tell us anything about your child we should know in order to better meet his/her needs:</td>
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<tr>
<td>Do you or does any member of your family have a special need, disability, or handicap for which additional accommodation is needed? If so, please describe:</td>
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<tr>
<td>Does the current facility provide for those needs? If not, please let us know how we can better serve your family:</td>
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<tr>
<td>Are there any foods your child cannot eat due to allergies or religious/cultural tradition? If yes, please have your physician complete the Medical Statement form following. <em>If any food restriction appears at a later time, it is imperative that you inform the administrative office; the staff will in turn inform the kitchen and classroom staff and place the information in your child’s permanent file.</em></td>
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<td>Other comments:</td>
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FAMILY’S INFANT DIAPERING/TOILETING/FEEDING PROCEDURES

Child’s Name

Diapering Procedure (Include type of diaper, cleanser (wipes), and any ointments used):


Toileting/Potty Training Procedure (Please read section in Family Handbook section on Toilet Learning Procedures):


Feeding Procedure (Please describe your child’s ability to feed him/herself, and also list any food allergies):


Parent/Legal Guardian Signature

Date
Dear Parent/Guardian:

The UCSD Early Childhood Education Center participates in the Child and Adult Care Food Program (CACFP) offered by the United States Department of Agriculture (USDA) and serves meals at no separate charge to all enrolled children. The reimbursement received from the CACFP helps with our food costs, and therefore, enables us to keep our fees for care as low as possible.

Please help us comply with the requirements of the U.S. Department of Agriculture’s (USDA) Child and Adult Care Food Program (CACFP). **All families must complete, sign, and return the attached Meal Benefit Form to the center as soon as possible, regardless of your family qualification.** All children enrolled in our center receive their meals at no separate charge, but the determination of eligibility category affects the amount of funding received by our center. This information is necessary to receive the reimbursement for the meals we served to children in our program. If your first language is not English, you have a right to ask us for written or oral translation of these materials free of charge in your native language.

If your household currently receives benefits under the Food Stamp Program; the California Work Opportunity and Responsibility for Kids (CalWORKs); the Kinship Guardian Assistance Payment (Kin-GAP); or the Food Distribution Program on Indian Reservations (FDPIR), you only need to list your current Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number on the Meal Benefit Form. You must also have an adult sign and date the Meal Benefit Form.

However, if your household does not receive benefits under Food Stamp, CalWORKs, Kin-GAP, or FDPIR, please complete the Meal Benefit Form and make sure you:

- provide the names of all household members and their income by source; and
- have an adult sign, date, and provide his or her social security number, or check the box “Check here if no Social Security Number” if the adult does not have a social security number.

**For All Households:**

The USDA defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses). Therefore, the income reported on the Meal Benefit Form must include the gross income of all members of your household, by source.

The income you report must be the total gross income received last month, listed by source for each household member. If last month’s income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last year’s income as a basis to make this projection. If your household’s income is equal to or less than
the amounts indicated for your household's size on the attached Income Chart, the center receives a higher level of reimbursement for meals served to your child(ren).

Once properly approved for free or reduced-price benefits, whether through income or proof of benefits as supported by a current Food Stamp, CalWORKs, Kin-GAP, or FDPIR case number, your child(ren) will remain eligible for those benefits for 12 months.

**Foster Children:**

For households with foster children, please refer to the Instructions on How to Complete the Meal Benefit Form or contact us for additional information.

**Confidentiality of Information on the Meal Benefit Form:**

We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We will place the Meal Benefit Form in our food program files and keep the information confidential. Only upon your request, will we share the information on your form with officials of other child nutrition, health, and education programs so they can use it to determine benefits for those programs.

**Nondiscrimination Statement:**

This explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U.S. Department of Agriculture policy, this agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington DC 20250-9410, or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Thank you for your cooperation. If you have any questions or need assistance in filling out the Meal Benefit Form, please contact:

<table>
<thead>
<tr>
<th>CENTER REPRESENTATIVE</th>
<th>TELEPHONE NUMBER</th>
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<tbody>
<tr>
<td>Esther Shin</td>
<td>(855) 242-8920</td>
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</table>

Sincerely,

[Signature]

Agency Representative Signature   9/1/14  Date
MEAL BENEFIT FORM FOR CHILDREN
PROGRAM YEAR 2015

Name of Child Care Center: UCSD Early Childhood Education Center

Please read the instructions. If you need help completing this form call: (858) 246-0900

Complete, sign, and return form to:

1. CHILD INFORMATION
(List names of all children enrolled for care)

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<th>Last</th>
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Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

If all children are foster children, go to #4 and sign this form.

☐

☐

☐

☐

2. BENEFITS
(If you are receiving CalFresh, CalWorks, FDPIR, or Kin-GAP benefits for your child, list the case number and do not complete #3. Go to #4.)

CalFresh Case Number:

CalWorks Case Number:

FDPIR Case Number:

Kin-GAP Number:

3. ALL HOUSEHOLD MEMBERS
(Complete this section if you did not complete #2. List all household members. List all income. Go to #4.)

<table>
<thead>
<tr>
<th>NAMES</th>
<th>GROSS INCOME and how often it was received (e.g. weekly, every 2 weeks, twice a month, monthly, or annually)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)</td>
<td>EARNINGS FROM WORK BEFORE DEDUCTIONS</td>
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</table>
4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

(PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, Kin-GAP, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

<table>
<thead>
<tr>
<th>Printed Name:</th>
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<tbody>
<tr>
<td>Last Four Digits of SSN:</td>
</tr>
<tr>
<td>□ Check here if no SSN</td>
</tr>
<tr>
<td>Signature of Adult:</td>
</tr>
<tr>
<td>Date:</td>
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</table>

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, Kinship Guardian Assistance Payment Program (Kin-GAP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, FDPIR, or Kin-GAP office to determine current certification for CalFresh, CalWORKs, FDPIR, or Kin-GAP benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

<table>
<thead>
<tr>
<th>If you choose to do so, please mark one or more of the following racial identities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ American Indian or Alaskan Native</td>
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<tr>
<td>□ Native Hawaiian or Other Pacific Islander</td>
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</tbody>
</table>

Please mark one of the following ethnic identities:

| □ Hispanic or Latino   | □ Not Hispanic or Latino |
U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call 866-632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax 202-690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

"USDA is an equal opportunity provider and employer."

Note: The protected classes for the Child and Adult Care Food Program are race, color, national origin, age, sex, and disability.

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FOR AGENCY USE ONLY

CATEGORICAL ELIGIBILITY

CalFresh/CalWORKS/FDPIR/Kin-GAP household categorically eligible free?  □ Yes  □ No

Foster child automatically eligible free?  □ Yes  □ No

INCOME ELIGIBILITY Annual Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income:  Household Size:

Eligibility Classification  □ Free  □ Reduced Price  □ Base

Determining Official (Print Name):

Determining Official Signature:  Certification Date:
HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the Meal Benefit Form to:

If you need help, call:

1. **CHILD INFORMATION:**
   a) Print your child’s name.
   b) Check box to right of name if a foster child.
   c) Include the name of the child care center.

2. **BENEFITS:** Complete this section and sign the form in #4.
   a) List your current CalFresh, CalWORKs, FDPIR or Kin-GAP case number(s) for your child(ren).
   b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. **ALL OTHER HOUSEHOLDS:** Complete this section and sign the form in #4.
   Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.
   a) Write the amount of income each person received last month before taxes or anything else was taken out and where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported. Each income amount should be entered in the appropriate column on the form. If any amount last month was more or less than usual, write that person’s usual monthly income.
   b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
   c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box “Check here if no SSN.”

4. **LAST FOUR DIGITS OF SSN AND SIGNATURE:**
   a) The form must have a signature of an adult household member.
   b) The adult household member who signs the statement must include the last four digits of his/her SSN. If he/she does not have a SSN, check the box “Check here if no SSN.” The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, FDPIR, or Kin-GAP case number.

5. **RACIAL/ETHNIC IDENTITY:** You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

<table>
<thead>
<tr>
<th>Earnings from Work:</th>
<th>Pensions/Retirement/Social Security</th>
<th>Other Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages/salaries/tips</td>
<td>Pensions</td>
<td>Disability benefits</td>
</tr>
<tr>
<td>Strike benefits</td>
<td>Supplemental security income</td>
<td>Cash withdrawn from</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Retirement income</td>
<td>savings</td>
</tr>
<tr>
<td>compensation</td>
<td>Veteran’s payments</td>
<td>Interest dividends</td>
</tr>
<tr>
<td>Worker’s</td>
<td>Social Security</td>
<td>Income from</td>
</tr>
<tr>
<td>compensation</td>
<td></td>
<td>estates/trusts/investments</td>
</tr>
<tr>
<td>Net income from</td>
<td></td>
<td>Regular contributions</td>
</tr>
<tr>
<td>self-employment</td>
<td></td>
<td>from persons not living in the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>household</td>
</tr>
<tr>
<td>Child Support/Alimony</td>
<td></td>
<td>Net royalties/annuities/net</td>
</tr>
<tr>
<td>Public assistance</td>
<td>Retirement Income</td>
<td>rental income</td>
</tr>
<tr>
<td>payments</td>
<td>Veteran’s payments</td>
<td>Military allowance for</td>
</tr>
<tr>
<td></td>
<td>Social Security</td>
<td>off-base housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any other income</td>
</tr>
</tbody>
</table>

WIN 2015 / CACFP 29 (REV. 1/2015)
DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American—A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino
MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

<table>
<thead>
<tr>
<th>1. School/Agency Name</th>
<th>2. Site Name</th>
<th>3. Site Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regents, University of California San Diego</td>
<td>Early Childhood Education Center</td>
<td>(858) 246-0900</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Name of Participant</th>
<th>5. Age or Date of Birth</th>
<th>6. Name of Parent or Guardian</th>
<th>7. Telephone Number</th>
</tr>
</thead>
</table>

8. Check One:

- Participant has a disability or a medical condition and requires a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.

- Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, or nurse practitioner must sign this form.

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation-use extra pages as needed)

12. Indicate texture:
   - [ ] Regular
   - [ ] Chopped
   - [ ] Ground
   - [ ] Pureed

13. Foods to be omitted and substitutions: (Please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed)

   **A. Foods To Be Omitted**
   - 
   - 
   - 

   **B. Suggested Substitutions**
   - 
   - 
   - 

14. Adaptive Equipment:

15. Signature of Preparer*

16. Printed Name

17. Telephone Number

18. Date

19. Signature of Medical Authority*

20. Printed Name

21. Telephone Number

22. Date

* Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
PERMISSION TO APPLY SUNSCREEN

CHILD’S NAME: ________________________________________________________

As the parent/legal guardian of the above child I recognize that too much sunlight may increase my child’s risk of getting skin cancer. Therefore I give my permission for staff at the UCSD Early Childhood Education Center to apply a sunscreen product of SPF-15 or higher on my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose, bare shoulders, arms and legs.

I have checked all applicable information regarding the type and use of sunscreen for my child.

☐ DO NOT apply any sunscreen to my child
☐ My child has allergies to sunscreen
☐ My child DOES NOT have allergies to sunscreen
☐ I will apply sunscreen before arrival or upon arrival at the Center and do not wish the Center Staff apply sunscreen to my child
☐ I request Center Staff apply sunscreen to my child
☐ I have provided the following brand/type of sunscreen for use on my child

☐ My child is allergic to some sunscreens. Please only use the following brand and type.

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child’s body

_________________________________________  _________________________
SIGNATURE OF PARENT/LEGAL GUARDIAN        DATE
NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child’s record and in the personnel file. A separate form must be filled out for each person who administers inhaled medication to the child.

I, ____________________________, give my consent for ____________________________, (PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at UCSD Early Childhood Education Center ____________________________, (PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, ____________________________, and to contact my child’s health care provider. ____________________________, (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child’s physician, or from a health care provider working under the supervision of my child’s physician (for example, a physician’s assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician’s prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician’s prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician’s prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child’s physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE ____________________________

ADDRESS OF AUTHORIZED REPRESENTATIVE ____________________________

HOME TELEPHONE NUMBER ____________________________ WORK TELEPHONE NUMBER ____________________________

UC 9165 (2011)
HUMAN DEVELOPMENT PROGRAM/ECEC

COOPERATION AGREEMENT

Dear Parents,

Each quarter, the Early Childhood Education Center & Mesa Child Development Center cooperates with the UCSD Human Development Program, providing an opportunity for those students to observe children in their regular day. From this “in the field” research, students establish a project.

Typical project topics include:

- Gender and Play
- Socialization
- Cultural Differences
- Effects of a Group Care Environment

Each group of HDP students attends an ECEC orientation and must have a current TB clearance before they begin observations in individual classrooms.

**Human Development Students are never alone with children.**

We believe it is important to provide such an opportunity to HDP students. By signing below, you agree for your child to possibly be included in the group of children being observed. Questions or concerns may be addressed to the ECEC Director.

I agree that my child ________________________________ will participate in his/her normal daily activities with the understanding that he/she may be part of a group observation. I understand that all observations will take place in the normal day to day activities at the center.

______________________________________________  ________________________
Parent/Legal Guardian Signature                  Date
PERMISSION TO PHOTOGRAPH & VIDEO

I hereby give permission for my child(ren) __________________________, to participate in observational studies and to be photographed and/or videotaped at the University of California, San Diego Early Childhood Education Center (ECEC) during the regular course of program activities. It is my understanding that all images will be used only for ECEC education and research purposes approved by the Director, program enrichment activities, Center marketing, or for private use of the family of the child(ren) being photographed/videoed. I further understand that any images taken at the ECEC by either myself or other parties are not to be used other than stated above without express written permission and that my child's identity will not be disclosed.

Reasons for photography and/or videotaping at the ECEC include, but are not limited to:

- Children’s cubbies
- Field trips
- Special events
- Birthday celebrations
- Multi-cultural events
- Picture books for children
- Enhancement of children’s cognitive development
- DRDP Portfolios
- Research and/or teaching purposes

_________________________  __________________________
Parent/Legal Guardian Signature  Date

_________________________  __________________________
Parent/Legal Guardian Signature  Date

☐ I do not wish to have my child(ren)’s picture to be taken for any reason.
Request for Family Photograph

Please include a family photograph as part of your enrollment packet. There are two purposes for this request. One is to tighten up on security by giving the teachers and substitutes a reference to identify family members during pick-up times; the other is to ease any separation anxiety your child may have. Having your smiling faces in the classroom gives a sense of warmth and creates a sense of community as other parents reference the photos and identify each other.
# UCSD EARLY CHILDHOOD EDUCATION CENTER

## ECEC/MCDC 2015 - 2016 HOLIDAY CALENDAR

<table>
<thead>
<tr>
<th>Day of Week</th>
<th>Date</th>
<th>Holiday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday</td>
<td>July 3rd, 2015</td>
<td>Independence Day</td>
</tr>
<tr>
<td>Friday</td>
<td>September 4th, 2015</td>
<td>ECEC Staff Development Day</td>
</tr>
<tr>
<td>Monday</td>
<td>September 7th, 2015</td>
<td>Labor Day</td>
</tr>
<tr>
<td>Wednesday</td>
<td>November 11th, 2015</td>
<td>Veteran's Day</td>
</tr>
<tr>
<td>Thursday- Friday</td>
<td>November 26th - 27th, 2015</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td></td>
<td>December 24th - January 1st, 2016</td>
<td>Winter Closure</td>
</tr>
<tr>
<td>Monday</td>
<td>January 18th, 2016</td>
<td>Martin Luther King Day</td>
</tr>
<tr>
<td>Monday</td>
<td>February 15th, 2016</td>
<td>President's Day</td>
</tr>
<tr>
<td>Thursday</td>
<td>March 24th, 2016</td>
<td>ECEC Staff Development Day</td>
</tr>
<tr>
<td>Friday</td>
<td>March 25th, 2016</td>
<td>Cesar Chavez Day</td>
</tr>
<tr>
<td>Monday</td>
<td>May 30th, 2016</td>
<td>Memorial Day</td>
</tr>
</tbody>
</table>

***DETACH HERE***

### ACKNOWLEDGEMENT OF RECEIPT

(To be retained in child’s file)

Child(ren)’s Name: ___________________________ Room (s): ___________

By signature below I acknowledge that I have received a copy of UCSD ECEC/MCDC’s 2015-2016 Holiday calendar.

Parent/Legal Guardian Signature ___________________________ Date ___________
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Blueberry Muffin &amp; Orange Slices</td>
<td>Hummus &amp; Cucumber Slices</td>
<td>Zucchini &amp; Rice Soup</td>
<td>Zucchini Muffin &amp; Tangerines</td>
</tr>
<tr>
<td>French Toast, Strawberry Smoothie</td>
<td>Oatmeal &amp; Strawberry Smoothie</td>
<td>Hummus &amp; Cucumber Slices</td>
<td>Chicken Breast</td>
<td>Grilled Cheese Sandwich &amp; Broccoli</td>
</tr>
<tr>
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<td>Tuesday</td>
<td>Wednesday</td>
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</tr>
</tbody>
</table>

*Note: Milk served with breakfast and lunch daily.*
ACKNOWLEDGEMENT OF RECEIPT
(To be updated annually and retained in child’s file)

My child is enrolled full-time, during the Center’s hours of operation from 7:30 am to 5:00 pm, Monday through Friday. I understand that each day my child will participate in the California Department of Education’s Child and Adult Food Program and will receive those meals listed on the attached sample menu. Only those foods appearing on the sample menu will be served, however, actual menus for a particular day may be shuffled depending on the availability of certain foods.

By signature below I acknowledge that I have received a 5 Week Cycle Menu sample and understand my child, as a full-time enrollee, will be a recipient of these meals.

__________________________  ______________________
Signature                        Date

PERMISSION TO SUBSCRIBE TO UCSD “DAYCARE-L” LISTSERV

Please provide the Center’s administration with your Email addresses if you would like to be subscribed to the Early Childhood Education Center’s ListServ. This ListServ is provided as a service to all parents/guardians/authorized representatives to give up-to-date information on Parent Advisory Board activities, happenings at the Center you might need to be apprised of, calendaring items, and/or special events occurring in your child’s room. Unless requested, in writing, your name will be unsubscribed from this list once your child leaves the Center.

Please subscribe me to the “daycare-l” ListServ.

__________________________  ______________________
Parent Name & Email address (Please print)

__________________________  ______________________
Parent Name & Email address (Please print)

__________________________  ______________________
Parent Name & Email address (Please print)