中英幼兒園
Chinese Bilingual Preschool

Registration Form

Please submit with a $150.00 non-refundable registration fee.
Check payable to "**Chinese Bilingual Preschool**".

please provide a 2" x 2" photo of the applicant.

ATTACH HERE

Applicant Information:

Name: _____
FIRST MIDDLE LAST CHINESE IF APPLICABLE

Gender: ☐Female ☐Male Date of Birth: _____

Ethnicity: _____ Language Spoken at Home: _____

Would Like to Attend: ☐Part Time, requested days: ☐M ☐T ☐W ☐TH ☐F
☐Full Time

Family Information:

Home Address: _____
STREET STATE ZIP CODE

Home Phone: _____

Parent 1 / Guardian 1:

Name: _____
FIRST MIDDLE LAST CHINESE IF APPLICABLE

Relationship to Student: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Parent 2 / Guardian 2:

Name: _____
FIRST MIDDLE LAST CHINESE IF APPLICABLE

Relationship to Student: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Please inform us on any special conditions your child may have: special needs, custody issues, allergies, etc.

_____

_____

中英幼兒園
Chinese Bilingual Preschool
5075 Ruffin Road
San Diego, Ca, 92123
Tel: (858)633-2950 Fax: (858)278-8899

Parent Permission Form

While your child is enrolled in our preschool, he/she will be involved in certain activities for which we need your permission.

Sometimes, we have special field trips or special lessons, such as how to cross the street. For such a lesson, we need your permission to guide your child across the street with the whole class.

Often, our teachers will take photos of the children during special activities for parents to see in our monthly newsletter, brochures, or post on classroom boards. We need your permission in order to take photos of your child during these special events.

_____

Print Child's Name

Please write your initials below.

I understand that participation in special field trips or special lessons are voluntary and may expose my child to some risk(s). I have read and understood this parental permission form and authorize my child to participate in special lessons or field trips. I understand that certain field trips may involve activities off school property. My child and I release any and all claims, including negligence, against the owners, employees, representatives, or volunteers of Chinese Bilingual Preschool, arising from participation from special field trips or special lesson activities.

A. ____ I give permission for my child to participate in special field trips or special lessons.

____ I do not give permission for my child to participate in special field trips or special lessons.

B. ____ I give permission for my child to be photographed or video for educational and publicity purposes.

____ I do not give permission for my child to be photographed or video for educational or Publicity purposes.

Signed by child's mother_____ Date_____

Signed by child's father _____ Date_____

ncw(8/13/2014)

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Preschool Admission Questionnaire

Name of Child _____

Date _____

Questionnaire Completed By _____

Please answer the following questions so we may learn more about your child.

1. Do you or your child speak any language other than English?
   If yes, please list_____
   If Chinese, please tell us which dialect(s)?_____
2. Has your child attended another school before? Yes / No
   Name of school_____ Reason for leaving_____
3. Does your child have allergies? Yes / No
   If yes, please explain _____
4. Does your child take prescription drugs? Yes / No
   If yes, please explain _____
5. What methods do you use to discipline your child?
   _____
6. Are there any cultural or family holidays you might like to share with us?
   _____
7. Please indicate if you have objections to cultural, family or religious celebrations.
   _____
8. Any special needs of your child?
   _____
9. What kind of experience would you like from our preschool for you and your child?
   _____

Please indicate yes or no to the following questions regarding your child's development.

	Yes	No
A. Social and Emotional Development		
Works and plays independently	___	___
Works and plays cooperatively	___	___
Shows age-appropriate attention span	___	___
Follows Directions	___	___
Engages in group activities	___	___
B. Physical Development		
Run, walk, and move freely	___	___
Ride tricycle	___	___
Put puzzles together	___	___
Cut with scissors	___	___
Hold a pen or crayon correctly	___	___
Use left hand ___ Use right hand___ or both hands	___	
C. Language Development		
Express himself or herself	___	___
Understand spoken language	___	___
Use correct grammar	___	___
D. Cognitive Development		
Knows his/her first name	___	___
Knows his/her last name	___	___
Recognize own written name	___	___
Recognize some letters	___	___
Recognize some numbers	___	___
Follow two or three commands	___	___
Identify colors	___	___
Identify some shapes	___	___
E. Self-Help Skills		
Uses toilet	___	___
Eats independently	___	___
Dresses independently	___	___
Naps independently	___	___
Puts toys away independently	___	___

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 Regional Office, Dept of Licensing

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

   Licensing Office Telephone #: (619) 767 - 2243

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
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

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:

Mission Valley Regional Office

NAME

Dept. of Licensing

ADDRESS

7575 Metropolitan Dr. Suite 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Diego	92108	(619) 767 - 2243

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?

IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

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

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

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

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

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

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

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

WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?*

DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?*

DIET PATTERN (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES? | ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE.* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"* | WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS:

DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

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

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE | DATE

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

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

DATE OF ADMISSION	DATE LEFT

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

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

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

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

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter _____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____ a.m./p.m. to _____ a.m./p.m., _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) _____ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Vision:

Developmental:

Language/Speech:

Dental:

Other (Include behavioral concerns):

Allergies: medicine:

Insect stings:

Food:

Asthma:

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

CHILD BLOOD LEAD TEST COMPLIANCE FORM

In accordance with Section 54.1011 of the City of San Diego's Lead Hazard Prevention and Control Ordinance (effective May 9, 2008), all child care centers or employee operated child care centers in the City of San Diego are required to collect evidence of a blood lead test for each new enrollment for children between the ages of six months and seven years of age inclusive. Please use this form to have your physician verify the test was completed, and return it to our office. Proof of blood lead screening is to be provided prior to admission, but in no event later than thirty days after admission.

This test can be conducted by your current health care provider and costs are typically covered by most health care insurance plans. If your child is not insured and you need assistance in paying for the blood lead test, or if you would like more information about the ordinance or childhood lead poising prevention, contact the City of San Diego's Lead Safe Neighborhood Program at (858) 694-7000, or visit their website at www.leadsafeneighborhoods.org or email at lead-safe@sandiego.gov.

Parent or legal guardian: _____
Print Name

Address: _____
Street City Zip

Child's Name: _____

Date of Birth: _____

Physician use only

On _____ the above listed child was screened for lead poisoning
Date
in accordance with applicable criteria mandated by the State of California.

Physician: _____
Print Name

_____ _____ _____
Physician's Signature Date Phone#

Childhood lead poisoning is the greatest ***preventable*** environmental disease affecting children today. The highest risk is for children under six as their brains and nervous systems are still developing and are more sensitive to the damaging effects of lead. Medical research in the past five years identifies there is no safe level of lead exposure in children. The highest loss of intelligence quotient, an average of 7.3, occurs below the Center for Disease Control and Preventions level of concern of 10 micrograms of lead per deciliter of blood. Additional research in 2008 shows compelling evidence linking childhood lead poisoning to criminal activity later in life.