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

Nutrition and Allergy Information

LePort Montessori

Child's Name _____ Gender _____ Birthdate _____

1. Nutrition Preferences, Restrictions & Food/Environmental Allergies–*complete for every child*

My child does not eat certain foods due to personal or religious beliefs: ❒ Yes ❒ No
If yes, please describe your child's food restrictions and any special dietary requirements below:

My child has food and/or environmental allergies: ❒ Yes ❒ No
If yes, you must complete the food/environmental allergy information (Section 2) below. If your child acquires a new food or environmental allergy, you must notify us immediately and provide an updated version of this form.

2. Allergy Information— *complete for every child with allergies (dietary and/or environmental)*

In response to eating one of his/her food allergens or being exposed to his/her environmental allergen, has your child ever experienced one of the following:	Yes	No
He/she has had a systemic allergic reaction (e.g., hives over larger parts of his/her body, severe stomach pains, nausea or vomiting, breathing problems).	❒	❒
He/she has needed medical attention during an allergic incident (e.g., has been taken to the pediatrician's or allergist's office, taken to urgent care or an ER, called 911, or had injectable epinephrine administered).	❒	❒
He/she has been prescribed an epinephrine auto-injector (EpiPen, AuviQ, or similar).	❒	❒

If you answered yes to any of the above questions, to enroll your child at LePort Montessori, you will need to either (1) provide an epinephrine auto-injector for us to keep at school, or (2) provide a written notice from your child's physician that an epinephrine auto-injector is not required for your child to be safe. You will also need to provide a written, detailed treatment plan provided or approved by your physician, for our staff to follow in case of an allergic reaction.

Food or Environmental Allergen *--e.g. peanuts, walnuts, egg, dairy, etc. or grass, pollen, dander, etc.*	Description of Severity of Allergy, Expected Symptoms & Treatment— *e.g., anaphylactic/life-threatening (may lead to vomiting, breathing problems…), or mild (hives, itching); and if Benadryl, inhaler/ nebulizer or any other medication should be used as treatment*	Epi for Treatment? *Epinephrine required to treat this allergen?* Yes	No
		❒	❒
		❒	❒
		❒	❒
		❒	❒

❒ Check here if 1) your child has more than four food or environmental allergies so we may discuss in person and prepare an addendum to this form; or 2) regardless of the number of your child's food/environmental allergies, you would like to discuss in person so we may better understand your child's needs with respect to allergies.

3. Allergy Medication & Topical Products Consent and Administration Authorization— *complete for every child.*

This medication should be provided to my child as needed from the date of this form through August 31, 2027. I authorize LePort Montessori to administer the above prescription(s) and/or over-the-counter medication to my child as indicated above. I further authorize LePort Montessori to administer any and all topical products to include but are not limited to: Sunscreen, diaper cream, chapstick and lotion. I understand that it is my responsibility to provide LePort Montessori with any and all medications and topical products, and full treatment plan, as necessary to treat my child's allergies and/or medical condition. It is also my responsibility to verify the expiration date(s) of any medications supplied to the school and make note of the date(s) to provide the school with replacement medications. I will inform LePort Montessori if I become aware that my child is allergic to any food(s) and/or if my child is no longer allergic to an item. I understand that all prescription or over-the-counter medications and topical products must be provided in the original packaging with appropriate labels affixed. In addition, if I have provided an epinephrine auto-injector to LePort Montessori for my child, I must also provide a case that will maintain a proper temperature for the device, when stored indoors and carried outdoors.

Parent Name _____ Signature _____ Date _____

For School Office Use Only

❒ ProCare
❒ Allergy list (classroom, office, emergency backpack & snack cupboard)
❒ HOS informed
❒ Meeting not required
❒ Meeting required & scheduled: Date _____ Time_____
❒ Allergy info & meeting notes provided to Head Teacher/Homeroom Teacher

Field Trip, Transportation & Medical Release

LePort Montessori

Child's Name _____ Gender _____ Birthdate _____

1. Field Trip Permission and Transportation Release

I/we, the undersigned parent(s) or guardian(s) of _____, a minor, do hereby request that he/she be permitted to attend LePort Montessori field trips and activities scheduled throughout the school year (from the date on this form through August 31, 2027). Said field trips and activities may refer to a range of activities, including but not limited to, the child being taken off campus for walks, hikes, parent-chaperoned going-out trips, and, for infants, buggy rides through the neighborhood.

List any medicines your child requires at school and may need to take with him/her on field trips (to include but not limited to Epi-Pen or Inhaler/Nebulizer). List any medical conditions and developmental issues that must be known on field trips your child takes:

I/we understand that neither LePort Montessori, nor any of its officers, administrators, teachers, staff, or parent chaperones are liable for any accident or injuries that may occur to the above-named student as a result of any aspect of his/her participation in any school-sponsored field trip or activity.

Parent name _____ Signature _____ Date _____

2. Essential Contact and Emergency Information Copied from Other Forms — *This form goes with child on field trip; below essential information needed for safety may be duplicated from other forms.*

	Name	Phone to call in case of an emergency
Parent/Guardian #1		
Parent/Guardian #2		
Pediatrican or primary care provider		
Dentist or orthodontist		

Insurance company _____ Policy ID# _____

My child has food allergies: ❒ Yes ❒ No

If yes, the child's food allergy form, allergy treatment plan, and (if provided) epinephrine auto-injector or other allergy medications must be taken on the field trip *and stay with the child throughout the trip. A food allergy safety adult (child's parent, teacher, or volunteer chaperone) may, at the parent's request, be designated, be trained on the child's allergies and treatments, and stay in the child's field trip group for the entire time of the trip. The child may be asked to wear allergy identification to help keep him/her safe.*

My child does not eat certain foods due to personal or religious beliefs: ❒ Yes ❒ No
If yes, please describe your child's food restrictions and any special dietary requirements:

3. Emergency Medical Release

I/we hereby authorize LePort Montessori personnel to seek medical attention for my child in the event of an emergency. I/we, as parent/guardian(s) also authorize LePort Montessori personnel to transport my child to the appropriate medical facility in the event that urgent/emergency medical care is necessary, or to call 911. The hospital and its medical staff have my authorization to provide any treatment which a physician deems necessary for the well-being of my child. It is understood that every effort shall be made to contact me/us prior to rendering treatment to my child, but that necessary treatments will not be withheld if I/we cannot be reached. I will not hold liable LePort Montessori, its officers, staff, or volunteer parents for medical aid rendered during a field trip, at school, or at the hospital/medical provider office, and will reimburse LePort Montessori for medical or other expenses incurred in the care of my child. This authorization is given pursuant to Section 6910 of the Civil Code of California and remains in effect from the date of this form through August 31st, 2027.

Parent name _____ Signature _____ Date _____

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

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

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

LePort Montessori . This Child Care Center/School provides a program which extends from 7 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:00 a.m./p.m. , 5 days a week.

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

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

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

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
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:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

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

WALKED AT*	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

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: **Community Care Licensing Division**

   Licensing Office Address: **750 The City Drive South, Orange, CA 92868**

   Licensing Office Telephone #: **(714) 703-2800**

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 their personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet their 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 their 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 their choice. Attendance at religious services, either in or outside the facility, shall be voluntary. In Child Care Centers, decisions concerning attendance at religious services shall be made by the child's authorized representative.

(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		
Community Care Licensing Division		
ADDRESS		
750 The City Drive South		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Orange	**92868**	**(714) 703-2800**

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)

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
( )	( )

Modification Request Form

STUDENT NAME: _____ **GRADE:** _____ **DATE OF BIRTH:** _____

Would your child need assistance and/or modifications in order to fully participate in this school's programs and services?

Check one: ☐ **No** (Please skip the Request section below, and sign/date the bottom of this form)

☐ **Yes** (Complete the rest of this form, sign and submit the form with supporting documents, if any)

You may change your election on this form at any time, by providing written requests to Principal or Assistant Principal.

Request – to be completed by Family

If you responded Yes above, please describe any requests for modifications to our school's programs and services.

Describe the reason for each requested modification:

Requested Modifications to School Policies or Programs:

☐ **Use a separate sheet of paper, if you need more space**

Please provide any supporting documents to help the school understand the student's abilities, needs, and any current or pending support services for the student, including but not limited to:

- ☐ Documents from the student's health care providers
- ☐ Documents from a therapist or a public school district that evaluated the student (e.g. IEP)
- ☐ Others: _____

We only need information relevant to the requested modifications.

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

To Be Completed by School					
School Name		School Number		Principal	
Date Received		Person Received			