



SunRISE, Child Development Center

Enrollment Packet

Welcome to **SunRISE, Child Development Center**, an exciting new program open to 3-5 year old children, located on the corner of Omega and Grafton on the Esparto Elementary School campus.
26137 Grafton St.
Esparto, CA 95627

The daily program begins at 7 a.m. and ends at 6 p.m. Monday - Friday.

Children may be dropped off between 7 a.m. and 8:00 a.m. The session will begin with breakfast, followed by circle time, activities, morning snack, outdoor exploration, lunch (from noon to 1 p.m.) and will follow a nap/rest time (required by State Licensing criteria). We will end the day with an afternoon snack and more purposeful free play and exploration. Pick up time no later than 6 p.m.

We are interested in: (Please mark one)

- Half-Day (\$400)** -- AM Session 7am-1pm PM Session 1PM-6PM
or
 Full Day (\$600)

Daily curriculum is based on play and land-based learning philosophy that promotes learning rooted in what is local and reflected in the ecology of the Capay Valley community. Learning and social interaction within nature and the outdoors is the mainstay for our children's activities. Animals, gardening, water play, drama, storytelling, art, music and physicality all happen within our specially-designed landscape. Our teaching philosophy is based on Early Childhood Development research that emphasizes a peaceful and natural environment for children to develop intellectually, physically, emotionally and socially. Graduates of SunRISE, Child Development Center, will be excited and ready for their upcoming kindergarten experience.

In partnership with Capay Valley Vision and RISE, Inc., the Center and program has been funded by Yolo First Five, IGLCBC, Yocha Dehe Wintun Nation, local community farmers, leaders, and volunteers. Operated by RISE Inc., all tuition and fees go toward the operation and administration of the preschool/childcare program.

For enrollment applications and information please email Jessica@riseinc.org
P: 530-507-3110

Please have your child's doctor complete this form and have them attach your **child's record of immunizations**, (this is a requirement by the State of California for all childcare centers). *These forms must be completed and turned in to SunRISE Child Development Center before the first day of school.* Please contact us if you have any questions.

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)
_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to _____ a.m./p.m., _____ days a week.

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

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

(TODAY'S DATE)

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

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____
Vision: _____ Insect stings: _____
Developmental: _____ Food: _____
Language/Speech: _____ Asthma: _____
Dental: _____
Other (Include behavioral concerns): _____
Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

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

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
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

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.

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

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

ILLNESS	DATES	ILLNESS	DATES	ILLNESS	DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS _____

DOES CHILD HAVE FREQUENT COLDS? 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

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
 ADDRESS
 CITY
 ZIP CODE
 AREA CODE/TELEPHONE NUMBER

Community Care Licensing
 744 P St MS T 9-3-52
 Sacramento 95814 1-844-538-8766

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 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

Licensing Office Address:

2525 Natoma Park Dr Suite 250 MS 19-29
Sacramento, CA 95833

Licensing Office Telephone #:

916-263-5744

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.

SUNRISE CDC
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

LIC 995 (9/08)

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

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

Sunrise
Child Development Center 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

()



SunRISE, Child Development Center

CHILD PROFILE

In order to know your child better, please complete this form.

The information below will be reviewed by your child's teacher and kept confidential.

Child's Full Name: _____ **Birthdate:** _____

Child's Nickname: _____ **Interests:** _____

Child's Primary Language: _____

Address: _____

Mother's Name: _____

Occupation: _____ **Interests:** _____

Father's Name: _____

Occupation: _____ **Interests:** _____

If child does not live with parents, who is primary care giver? What is their relationship to the child? _____

If child does not live with both parents, what are the custody arrangements?

Who are the members living with your child?

<i>Name</i>	<i>Age</i>	<i>Relationship</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have food allergies?

Nuts Dairy Eggs Wheat Gluten Other: _____

Does your child have non-food allergies?

Grass Hay Pollen Pet Hair Insect bites/stings Other: _____

What is the reaction?

Severe (anaphylactic) Slight (rash, irritation, upset stomach) Mild (itchy, rash, runny nose) Special Instructions regarding allergies: _____

Does your child have trouble with separation anxiety? Yes No

If so what helps? Not sure Redirection Talking about family

Other: _____

Do you have any family Pets? _____

Describe any fears your child may have _____

Describe your child's personality _____

What are your child's favorites?

Books _____

Cartoons _____

Breakfast Food _____

Lunch Food _____

Snack Food _____

Outside Activity _____

Indoor Activity _____

If your child has trouble falling asleep, what do you do? _____

How is conflict handled when it arises at home (ex: bedtime, getting dressed, clean-up or just in general non-compliance)? _____

What are your expectations for your child's experience here at SunRISE, Child Development Center?

Is there anything else you would like to share about your child?

THANK YOU