REGISTRATION FORM

Name of Child: ___________________________________ Age: _______ D.O.B.: _______________ Gender: ______

Address: ____ Zip: _________________________

Mother's Name: _________________________________ Father's Name: ____________________________________

Mother's Email: _________________________________ Father's Email: ___________________________________

Mother's Cell #: __________________________________ Father's Cell #:__________________________________

Mother's Occupation: ____________________________ Father's Occupation: _______________________________

Sibling's age(s): __________________________ How did you hear about Magic Hours? ________________________

Name of other school or daycare previously attended? ____

Please list any behavior, emotional, or physical problems your child may have: ______________________________

____

____

What do you expect from preschool? ____

____

Program Desired:

TUESDAY & THURSDAY	HALF DAY A.M. /P.M. _____________	FULL DAY _____________
MON., WED., & FRI.	HALF DAY A.M. /P.M. _____________	FULL DAY _____________
MON. THROUGH FRI.	HALF DAY A.M. /P.M. _____________	FULL DAY _____________

- Half day programs are from 6a.m. to 12p.m. OR 1p.m. to 6p.m. (afternoon program available to Rm 3 only). All programs are contingent upon space availability, child's age, behavior, and development.

Registration Date: ________________________________ Enrollment Date: __________________________________

Registration Fee: ______________________________ Paid on: ____

Tuition Payment: ____________________________ Deposit: _______________ Paid on: ______________________

- All tuition is due on the FIRST day that your child attends each week. All registration fees, deposits, and tuition are non-refundable.

I have read the Parent Pamphlet and agree to all policies including but not limited to admission, withdrawal, termination, and payment policies of Magic Hours Childrens' Center.

Parent Signature: ____ Date: _________________________

School Representative: ____ Date: ________________________

8330 Westmore Road, San Diego, CA 92126 * Phone (858) 271-8383 * Fax (858) 271-8384 * www.magichourspreschool.com

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

To Be Completed by Parent, Domestic Partner or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'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, DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	DATE LEFT

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE

FATHER'S/DOMESTIC PARTNER'S NAME	DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/DOMESTIC PARTNER'S NAME	DOES MOTHER/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	WHAT ARE USUAL EATING HOURS? BREAKFAST ______
	LUNCH	LUNCH ______
	DINNER	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/DOMESTIC PARTNER'S SIGNATURE	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 ( )

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Domestic Partner/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: ______________________________

   Licensing Office Address: ______________________________

   Licensing Office Telephone #: ______________________________

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/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/DOMESTIC PARTNER/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 (1/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Domestic Partner/Authorized Representative Signature Required)

I, the parent/domestic partner/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/Domestic Partner/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/domestic partner/authorized representative.***

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

Magic Hours Childrens' Center
Health Policy & Attendance Exclusions

SYMPTOM	**KEEP CHILD AT HOME UNTIL:**
Symptoms of Illness	May include lethargy, sleeping, coughing, wheezing, persistent crying & irritability, or inability to function through daily routines.
Fever	Fever must register below 100° for a 24-hour period without the use of fever reducing medications.
Runny Nose	Thick yellow or green discharge is containable, and clears up, doctor has evaluated the issue and allows child to return to school.
Earache/Ear infection	Doctor examines the child and recommends the child return to school.
Sore Throat	Doctor determines the child doesn't have strep throat or is contagious. If antibiotic is necessary child may return 24 hours after antibiotic treatment has begun. Staff cannot administer any medications.
Body Rash/Diaper Rash	Diaper rash should be treated at home. A doctor determines the cause and gives child permission to return to school.
Cough	Coughing subsides, does not interfere with the child's school day, or is evaluated and treated by physician.
Pale/ Flushed skin	Color returns to what is normal for the child.
Conjunctivitis/Red or watery eyes	Eyes return to normal or doctor determines that there is no infection. 24 hours after treatment begins with doctors note to return to school.
Draining sore/Mouth sore	Until draining stops or scab begins to form and doctor determines it is not from communicable disease.
Upset Stomach/ Vomiting	Child has no other symptoms of illness, is eating normally and vomiting has stopped for 24 hours.
Diarrhea	Child has no other symptoms of illness. Diarrhea has stopped for 24 hours. Stools must be contained in diaper or child is able to get to toilet in time.
Chicken Pox/Shingles/Impetigo	May return after rash and sores have dried up and crusted over.
Head Lice/Scabies/	24 hours after treatment began. Must be completely lice and nit free.
Pertussis (Whooping Cough)	May return after antibiotic treatment and determined not contagious with a doctors note.
Mumps	Swelling has subsided and determined not contagious.
Hepatitis A	Directed by a doctor to not be contagious and appropriate measures have been taken for staff and children.

Measles	Doctor determines not to be contagious, rash has subsided.
Rubella	Doctor determines not to be contagious, rash has subsided
Tuberculosis (TB)	Until treatment has begun, fever is gone and doctor states the child is non-infectious.
Biting	Biting is an unacceptable act of social behavior that we consider a health hazard. If a child has a biting problem, parents are expected to respect and cooperate with staff to prevent further occurrences and to protect the children involved. Parent may be required to remove the child from the center for the remainder of the day.

Magic Hours Childrens' Center is not licensed to care for sick or injured children. If a child shows any symptoms of illness or demonstrates an inability to function in daily activities, parents will be called to pick up their child. If the parent is unavailable, the persons on the emergency information record will be contacted. In the best interest of all of the children in our care, we have the right to refuse care for any child with any symptoms or signs of illness. Before a child may return to school, a doctor's note may be required for any of the above symptoms or illnesses.

- **All the above symptoms/illness require a doctor's note to return to school.**
- **Children may not return to school if they require medications to treat symptoms.**
- **Staff cannot administer antibiotics, eye drops, lotions, sunscreen or any medications either prescribed or over the counter.**
- **Children with certain medical conditions under the current care of a doctor may have an Incidental Medical Services Plan preapproved by MHCC Administration.**
- **Magic Hours Childrens' Center reserves the right to refuse services that would directly and adversely alter our quality of care and/or our program.**

Acknowledgement of Notification of Magic Hours Childrens' Center
Health Policy & Attendance Exclusions

By signing this document you agree to follow and adhere to the terms and conditions of Magic Hours Childrens' Center Health Policy & Attendance Exclusions stated above.

I, the parent/authorized representative of ___________________________________, have received a copy of the Magic Hours Childrens' Center Health Policy & Attendance Exclusions and agree to its terms and conditions.

____ ________________________

Signature of Parent/Guardian/Authorized Representative Date

Getting to Know Your Child

Child's Name____ D.O.B.__________________________________

What languages are spoken in your home? ____

What language does your child primarily use? ____

Does your child use language to express their wants or needs? ____

How many words does your child link together to create a sentence? __________________________________

Does your child interact with children their own age? ____

Does your child primarily get your attention by pulling your hand or pointing? ___________________________

Has your child had any previous developmental assessments? ____

If yes, where, when, and what for? ____

Does your child attend any additional therapy (i.e. Speech Therapy)? __________________________________

If yes, where and when? ____

Does your child need any special medical device (s)? ____

Does your child have any allergies? ____

List allergies child has: ____

Does your child take medications under a doctor's orders? ____

List all medications child takes: ____

Do you have concerns about your child's social, emotional or developmental stage? ______________________

Does your child require a specific item for comfort? ____

Does your child eat & drink independently? ____

Can your child use utensils to eat and open cups to drink from? ______________________________________

Does your child pee & poop in the toilet? ____

Does your child primarily wear underwear at home and in public? _____________________________________

Does your child take themselves to the potty? ____

Does he/she need reminders? ____

Can he/she pull own clothing up and down? ____

Can he/she clean own body? ____

Can he/she wash his/her own hands? ____

Parent 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)

_____________________________________ . 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:

Vision:

Developmental:

Language/Speech:

Allergies: medicine:

insect stings:

food:

asthma:

other:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

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

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

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.

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), domestic partner(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/DOMESTIC PARTNER/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

DETACH HERE

TO: PARENT/DOMESTIC PARTNER/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/DOMESTIC PARTNER/GUARDIAN)

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

Website/Social Media Photo Authorization Form

Magic Hours Childrens' Center occasionally features photographs of events and activities the children have enjoyed. Please check the following that apply and sign where indicated below:

○ I give permission to have my child's/children's picture posted on www.magichourspreschool.com website.

○ I give permission to have my child's/children's picture posted on Magic Hours Childrens' Center Yelp page.

○ I give permission to have my child's/children's picture posted on Magic Hours Childrens' Center Facebook page.

○ I **do not** give my permission to have my child's/children's picture posted on www.magichourspreschool.com website.

○ I **do not** give permission to have my child's/children's picture posted on Magic Hours Childrens' Center Yelp page.

○ I **do not** give permission to have my child's/children's picture posted on Magic Hours Childrens' Center Facebook page.

Please include name/names of child/children:

____

Signature____

Date____