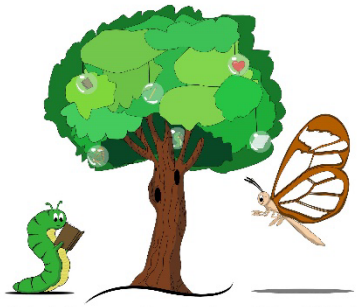
The Children's Place Child Development Center

Where little minds grow!



45-114 Smurr St. Indio, CA. 92201

(760) 619-3286

Licensed Facility # 334846127

Child Enrollment Application

TCPCDC

Application Information

Date Submitted: _____

Applicant First Name: _____ ***Applicant Middle Name:*** _____

Applicant Last Name: _____ ***Family Size:*** _____

Program year you're applying for:

☐ ***2023-2024***

☐ ***2024-2025***

Did your student attend "TCPCDC" a previous year?

☐ ***Yes*** ☐ ***No***

Parent/Guardian 1

First Name: _____ Last Name_____

Relationship to Child: _____ Is this parent/guardian the Head of Household? ☐ Yes ☐ No

Authorized to pick up children from the school? ☐ Yes ☐ No

Authorized to sign official documents? ☐ Yes ☐ No

Are you the primary contact for the household? ☐ Yes☐ No

Address Line 1: _____

City: _____ State: _____ Zip Code: _____

Ethnicity: ☐ Unknown ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race: _____

Home Phone: _____ Mobile Phone: _____ Text ok? _____

Work Phone: _____

Email: _____ Preferred method of contact: _____

Spoken Language: _____ Messaging Language: _____

Parent/Guardian 2

First Name: _____ Last Name_____

Relationship to Child: _____ Is this parent/guardian the Head of Household? ☐ Yes ☐ No

Authorized to pick up children from the school? ☐ Yes ☐ No

Authorized to sign official documents? ☐ Yes ☐ No

Are you the primary contact for the household? ☐ Yes☐ No

Address Line 1: _____

City: _____ State: _____ Zip Code: _____

Ethnicity: ☐ Unknown ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race: _____

Home Phone: _____ Mobile Phone: _____Work Phone: _____

Email: _____ Preferred method of contact: _____

Spoken Language: _____ Messaging Language: _____

Reason for Needing Service

☐ Working ☐ Parent/caretaker incapacitated ☐ Actively Seeking Employment

☐ Education or Training ☐ Homelessness ☐ Seeking Permanent Housing

☐ Diversion

☐ CalWORKs Activities ☐ Child referred for protective services because of neglect, abuse, exploitation or At-Risk thereof

If Working or Education or Training is selected, fill out the below fields:

Employment/School: _____ Phone Number: _____Start Date: _____

Address: _____ City: _____ Zip Code: _____

If the reason for needing service is Working, Education or Training, Actively Seeking Employment, Seeking Permanent Housing, or Diversion, fill out the below fields:

Monday Hours: _____ Tuesday Hours: _____ Wednesday Hours: _____Thursday Hours: _____

Friday Hours: _____

Child's Information

First Name: _____ Middle Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____

Parent(s) that the student lives with: _____

City of Birth: _____ State of Birth: _____ Country of Birth: _____

Photo/Video Consent: ☐ Yes ☐ No Ethnicity: ☐ Unknown ☐ Hispanic or Latino
☐ Not Hispanic or Latino Race: _____ Spoken Language: _____
☐ English Learner

Doctor's Full Name: _____ Doctor's Phone Number: _____

Heath Concerns:
☐ Heart Condition ☐ Asthma ☐ Seizures ☐ Food Allergy ☐ Bee Sting Allergy

Other allergies or health conditions: _____

Special needs:
☐ Active CPS Case ☐ Active Restraining Order ☐ At Risk

Further explain Active Restraining Order: _____

DESIRED PROGRAM:

☐ Full Day Toddler Program (2's) ☐ Full Day Preschool Program (3-5's)
Time Preferences: _____

Medication required at school:
_____
_____

Has Individualized Family Service Plan (IFSP)?
☐ Yes ☐ No

Individualized Family Service Plan (IFSP) Date:

Has Special Education services through an Individualized Education Program (IEP)?
☐ Yes ☐ No

Individualized Education Program (IEP) Date

OTHER CHILDREN IN THE HOME:

Name	Age	Grade	School

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
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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)

The Children's Place Child Development Center . This Child Care Center/School provides a program which extends from 6 : 30
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:00 a.m./p.m., Five 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

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*	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

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

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

The Children's Place 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
( )	( )

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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		
COMMUNITY CARE LICENSING		
ADDRESS		
3737 Main Street, Suite 700		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside	92501	(951) 782-4200

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)
THE CHILDREN'S PLACE CHILD DEVELOPMENT CENTER	45-114 Smurr Street Indio, CA. 92201

(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: 3737 Main Street, Suite 700 Riverside, CA. 92501

   Licensing Office Telephone #: (951) 782-4200

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.

THE CHILDREN'S PLACE CHILD DEVELOPMENT 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

PRESCHOOL (2-5 YEARS) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name _____ Date of Birth _____

Facility THE CHILDREN'S PLACE CHILD DEVELOPMENT CENTER Room _____

DAILY ROUTINES

SLEEPING

Please describe your child's usual bedtime routine (including what *time* and *where* he/she usually sleeps). _____

_____

How do you know that your child is sleepy/tired? _____

Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

_____

About how many hours of uninterrupted sleep does your child get each night? _____

Does your child nap? _____ How many hours on average? _____

Does your child sleep with a special blanket, toy, pacifier, song? _____

Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

EATING

Does your child generally enjoy eating? _____ Do you consider your child a good eater? _____

What are some of your child's favorite foods (temperatures, textures, etc.)? _____

Is your child on any special diet? _____

If your child has any food allergies, please list here: _____

ⓘ If child has food allergies, ensure a **Feeding and Nutrition Care Plan** is established and on file.

Are there any other foods you do not want us to offer your child? _____

Are there foods from your home/culture that you would like us to offer? _____

What does your child eat with? ❑ hands ❑ spoon ❑ fork

What does your child use to drink? ❑ bottle ❑ tippy cup ❑ regular cup

Do you have any concerns or questions about your child's eating habits? _____ If yes, please explain: _____

_____

TOILETING

What does your child usually wear during the day? ❑ underwear ❑ diaper ❑ Pull-ups For naps? _____

Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:

urine _____ bowel movement _____ genital area _____

Do you have any questions or concerns about your child's toileting habits? _____ If yes, please explain: _____

_____

PLAY

What is your child's favorite toy/object or song? _____

Does your child enjoy playing with others? _____ Does your child do well playing alone? _____

What activities and toys does your child enjoy? _____

HEALTH

Does your child have any health problems? _____ If yes, please explain: _____

_____

Is your child taking any medication(s) regularly? _____ If yes, please list: _____

_____

ⓘ If medications are to be given while in care, ensure a **Medication Administration Form** is utilized and on file for your child.

Does your child have a chronic health condition or specific health needs? (please be specific) _____

_____

ⓘ If yes, ensure a **Special Health Care Plan** is established and on file for your child.

Does your child have frequent ear infections? _____ diarrhea? _____

Do you have any concerns about your child's health? _____ If yes, please explain: _____

_____

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

Do you have any concerns about your child's:

- hearing and/or vision? _____
- speech and language development? _____
- ability to move? _____
- overall development? _____

What languages are spoken at home? _____

What is your family's cultural identification (values, traditions)? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever been in group child care? ❑ Yes ❑ No If yes, how many different settings? _____

How does your child respond in group situations? _____

What can we do to help your child adjust to child care? _____

How would you describe your child's temperament and personality? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

Does your child fear certain things? _____

How is your child disciplined? _____

What works best when you discipline your child? _____

Do you have any questions or concerns about your child's social/emotional development or behavior? _____ If yes, please explain:

_____

What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? _____

_____

Parent's Signature: _____ **Date:** _____