the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Stonestown Family YMCA

2019-2020 Afterschool Program Registration

Processed Date _____

Staff Initials _____

PROGRAM LOCATION

SCHOOL: ☐ Dianne Feinstein

APPLICANT INFORMATION

Student's Name: _____ Entering Grade _____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Decline to State Date of Birth: ____/____/____

Home Address: _____
Street City State Zip

Parent/Guardian E-mail: _____

Household Income (please check one):

☐ $0–$13,999 ☐ $14,000–$24,999 ☐ $25,000–$39,999 ☐ $40,000–$74,999 ☐ $75,000 and above ☐ Decline to state

PARENT/GUARDIAN 1
(Emergency contact & authorized to pick-up child)

Name: _____ D.O.B: ____/____/____

Primary Phone: _____

Secondary Phone: _____

PARENT/GUARDIAN 2
(Emergency contact & authorized to pick-up child)

Name: _____ D.O.B: ____/____/____

Primary Phone: _____

Secondary Phone: _____

ADDITIONAL AUTHORIZED PICK-UPS/EMERGENCY CONTACTS:

Pick-Up #1 Name: _____

Phone: _____

Pick-Up #2 Name: _____

Phone: _____

Pick-Up #3 Name: _____

Phone: _____

UNAUTHORIZED PICK-UPS:
(Anyone NOT authorized to pick up the child, please list here)

_____

List any allergies or medications we should know about:

Can your child participate in this program without additional supports?

☐ Yes
☐ No

If your answer is no, please state briefly the nature of the additional supports your child may need.

Does your child have one of the following?

☐ SST ☐ 504 ☐ IEP ☐ No

Do you authorize consent for program staff to access your child's SST, 504 and/or IEP?

☐ Yes*
☐ No

*If yes, please sign the attached SFUSD Authorization for Release of Confidential Information.

What else should we know to ensure your child has a successful experience in this program?

PURPOSE OF THE PROGRAMS The purpose of our programs is t o provide students with academic enrichment opportunities which are designed to complement students' regular academic program and provide a safe environment for students. Afterschool programs are designed in collaboration with the schools that the students attend are alignment with SFUSD guidelines.

American with Disabilities Act (ADA) Unlike the school day, which is required to comply with Individualized with Disabilities Education Act (IDEA), the afterschool program must comply with Americans with Disabilities Act (ADA). Services and activities provided by a public entity to the public, whether directly or through an agency, must be accessible to students with disabilities with reasonable accommodations (e.g. federal, state and local disabilities right such as Section 504). Enrollment in program can include query if student needs additional support but cannot use that information to influence enrollment. If a student has a 504 plan or IEP plan, the SFUSD program may request access to that information in order to identify what reasonable accommodations can be made to support access to program.

Safe and Supportive Environments Progressive Response to Challenging Behavior in collaboration with the school day, SFUSD programs must ensure policies and protocols within its program that are sufficient to ensure staff, student and family member safety. SFUSD programs are required to document injuries, referrals and crisis situations. Each agency will share their progressive response to challenging behavior with staff, student and families. Progressive Response to Challenging behavior should include universal practices across program to promote a safe and supportive community. It should also include internal processes for managing challenging behavior that may result in alternative consequences (e.g. Restorative Circles) or Their II intervention (e.g. Behavior Contract) or suspension from program.

YMCA OF SAN FRANCISCO PROGRAM EXPERIENCE SURVEY AUTHORIZATION

YMCA of San Francisco improves program quality and impact through member and participant surveys and date analysis. By signing this form, you authorize your child(ren) to participate in YMCA of San Francisco's anonymous and voluntary program experience surveys.

In addition to anonymous survey answers, we may collect the following participants information:

- Demographic information, such as race/ethnicity and gender identity;
- Education information, such as school name and grade level; and
- Participation in activities and services, such as attendance and hours attended.

YMCA of San Francisco will not disclose the personally identifiable information of you child(ren) and will limit the collection of survey answers and participant information to no more than is reasonably necessary to accomplish the purpose of the collection. YMCA of San Francisco does not rent or sell personally identifiable information, survey answers, or participant information, including information provided about children, to third parties. YMCA of San Francisco may share youth experience survey answers and participant information with trusted service providers in order to analyze such information and improve program quality and impact.

Student Name: _____

Parent Name: _____

Parent Signatire: _____ **Date:** _____

MONTHLY CO-PAY FEES PROGRAM

Applicants who are members of a YMCA facility are offered a reduced monthly co-pay. If you are interested in a YMCA Facility Membership, please visit our website at www.ymcasf.org. You may also sign up as a Community Participant at no cost (access to YMCA programs only).

Please check the box that you would like to register for:

Community Participant Rates			YMCA Facility Member Rates		
AFTER SCHOOL	**MONTHLY FEE (Sept-May)**	**DEPOSIT (August 2019)**	**AFTER SCHOOL**	**MONTHLY FEE (Sept-May)**	**DEPOSIT (August 2019)**
☐ 5 days/week	$498	$257	☐ 5 days/week	$446	$223
☐ 3 days/week	$357	$179	☐ 3 days/week	$309	$155
☐ 2 days/week	$305	$153	☐ 2 days/week	$262	$131

Please check all of the days your child will attend: ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY

PLEASE NOTE: One-day camps and weekly camps are available at additional fees. The following months are prorated due to school –year breaks: August, December and June

SIBLING DISCOUNT: We offer a 20% discount on monthly child care fees for siblings.

FINANCIAL ASSISTANCE: We offer financial assistance to qualifying families. If you are interested in applying, please complete a financial assistance application and submit with your income verification and registration packet.

☐ **YES! I am applying for the Monthly Co-Pay Fees Program** ☐ **YES! I have attached my Financial Assistance Application**

MONTHLY CO PAY FEES PROGRAM/ PAYMENT DUE AND BILLING POLICY

By signing below, I acknowledge and agree to the following:

- Monthly fees are paid automatically via EFT 10 days before the first of the month. If payment is not made, we will request permission from you 5 days after the due date via email to pay off your balance using your credit card/bank account on file. If we do not hear from you within 3 business days after our request, we will use the credit card/bank account on file to pay your balance.
- Parents must update billing information if there are any changes to their account, including credit card replacement and new expiration dates. This can be done online or at the main facility at 333 Eucalyptus Drive, SF, CA 94132.
- Parents will be contacted regarding returns from their account. It is the parent's responsibility to pay for childcare by the 1st of the month. Failure to do so will result in a $15 late payment fee. If payment is not received by the 10th, childcare will be terminated.
- A $15 bank fee will be charged for any returned payments.
- I acknowledge that the following month(s) are prorated: August 2019, December 2019 and June 2020
- I acknowledge that the following month's fees are non-refundable: August 2019
- **Refund Requirements:** A 30 day written or email notice is required for program cancellation (including school transfers) and a 14 day notice is required for schedule changes. **It is the parent's responsibility to notify the YMCA by written note or email.** Withdrawal of student from program is not considered notice of program cancellation and will not terminate childcare payments.

Parent/Guardian Name _____ **Signature** _____ **Date** _____

PAYMENT DUE

$ _____ Deposit: This pays for August 2019 fees (school year ends June 2nd)
Deposit is due at registration and NON-REFUNDABLE

$ _____ Donation to our Annual Campaign which supports financial assistance for qualifying families at Stonestown Family YMCA

TOTAL
$

Payment Method: Families in Monthly co-pay fee-based program must have an account on file for monthly drafts.
☐ Charge account on file ☐ I will provide new account information by contacting Stonestown Family YMCA 415-242-7100

STUDENT CONTRACT

Parent/Guardian: Please read this over carefully with your student.

I,_____, understand and agree to meet the following requirements of the program:
Student's Name

- I will report to program immediately after school and sign-in.
- I will make sure to be signed out when I leave.
- I will be in a supervised area at all times, and never leave the program alone whether on or off school grounds
- I will follow school rules and directions from staff members both during and after school
- I will be respectful to the adults and other students.
- I will not engage in bullying, name calling, or any inappropriate interactions with peers. I understand that this is not tolerated in any of our programs.
- I will use words to solve conflicts, or ask an adult for help. I will never use violence to solve a problem.
- I will leave electronics at home and get permission from a staff member before using my cell phone.
- I will take care of our school building and our equipment. I will clean up after myself.
- I will be open to activities, clubs, and enrichments.

I understand that if I break these rules:

- I may be asked to participate in a Restorative Meeting.
- If I continue to break the rules, or if the incident is serious, my parent/guardian will be contacted.
- If I fight in any of our programs, I will participate in Restorative Practices. Depending on the severity of the situation, I may be suspended from program.
- If inappropriate behavior continues, depending on the severity of the situation, I may be on a behavioral contract or suspended from program.

I understand that I must sign this contract in order to be admitted into the program. I also understand that by signing this contract I am agreeing to adhere to the rules.

Student Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

ABOUT YOUR STUDENT

This section asks for information that is required by one of our funders. The below information will in no way determine your student's status in the program or be used for any purpose other than program evaluation.

1. Student Race/Ethnicity (select one):

- ☐ African American
- ☐ Black-Other:
  Specify: _____
- ☐ Asian-Chinese
- ☐ Asian-Filipino
- ☐ Asian-Indian
- ☐ Asian-Japanese
- ☐ Asian-Korean
- ☐ Asian-Laotian
- ☐ Asian-Thai
- ☐ Asian-Vietnamese
- ☐ Asian-Other
  Specify: _____
- ☐ Hispanic/Latino-Mexican American
- ☐ Hispanic/Latino-Central American
- ☐ Hispanic/Latino-South American
- ☐ Hispanic/Latino-Caribbean
- ☐ Hispanic/Latino-Other
  Specify: _____
- ☐ Middle Eastern-Arab
- ☐ Middle Eastern-Iranian
- ☐ Middle Eastern-Other
  Specify: _____
- ☐ Native American
- ☐ Native Alaskan
- ☐ Pacific Islander-Guamanian
- ☐ Pacific Islander-Hawaiian
- ☐ Pacific Islander-Tongan
- ☐ Pacific Islander-Samoan
- ☐ Pacific Islander-Other
  Specify: _____
- ☐ White
- ☐ Multiracial/Multiethnic
- ☐ Other
  Specify: _____
- ☐ Decline to Specify

2. Home Language (select one):

- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Russian
- ☐ Japanese
- ☐ Khmer/Cambodian
- ☐ Korean
- ☐ Laotian
- ☐ Other:
  Specify: _____
- ☐ Mandarin
- ☐ Samoan
- ☐ Tagalog
- ☐ Taishanese
- ☐ Vietnamese
- ☐ Arabic
- ☐ Russian
- ☐ American Sign Language

3. Student English Fluency (select one):

- ☐ Fluent
- ☐ Somewhat Fluent
- ☐ Not Fluent

4. Housing Status

- ☐ Permanent/Stable Housing
- ☐ Homeless– Transitional /Supportive Housing
- ☐ Homeless– Shelter/Emergency Housing
- ☐ Homeless– Motel/Hotel
- ☐ Homeless– Staying with Friends/Family
- ☐ Homeless– Unsheltered
- ☐ Unknown

If Applicable:
PERMISSION TO ACCESS 504 PLAN OR INDIVIDUALIZED EDUCATION PLAN (IEP)

I authorize the exchange of information for _____ (student name) described below between the San Francisco Unified School District and the following agency(s) and/or individual(s):

☐ Agency(s) **YMCA of San Francisco** (Name)

This authorization applies to the following information (Check each line that applies):

☐ 504 Plan

☐ Individualized Education Plan (IEP)

Expiration: This authorization expires (date or event): June 2nd, 2020

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing the San Francisco Unified School District in writing. If you cancel your permission to allow the release of information about you/your child, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Parent/Guardian Signature _____ Date _____

Indicate relationship to student: _____ _____

If Applicable:
PHOTO/VIDEO RELEASE OPT OUT FORM

During your child's attendance in the ExCEL Afterschool Program, they may participate in an activity that is being photographed or videotaped; these photographs/video recordings may be used for promotional purposes.

Student Name: _____ Grade: _____

Parent Name: _____ Date: _____

By not submitting an opt out form, I authorize the SFUSD or any third party it has approved to photograph or videotape my child during Afterschool program activities and to edit or use any photographs or recordings at the sole discretion of SFUSD. I understand that I and my child shall have no legal right or interest arising from the recording, including economic interest. I also agree to release and hold harmless the SFUSD and any third party it has approved from and against all claims, demands, damages, and liabilities arising out of or use of the recording.

☐_____ (parent initial) I DO NOT give my permission for my child to be photographed/videotaped by the Afterschool program for promotional purposes.

Authorization for Release of Confidential Information

YMCA OF SAN FRANCISCO

Participant Name:_____Date of Birth: _____

Our agency is supported by a grant from the San Francisco Department of Children, Youth and Their Families (DCYF). As a condition of the funding we receive, we are required to report information about the services we provide and the children, youth, and families that we serve to DCYF. DCYF works in close partnership with the San Francisco Unified School District (SFUSD). The data that we report to DCYF is also shared with SFUSD.

By signing this form, you authorize our agency to share information about your child's participation in our program (or your participation, if you are 18 years of age or older) with authorized staff at DCYF and SFUSD for the purposes described above. The information that we report to DCYF includes:

- Personal information, such as name, date of birth, and address;
- Demographic information, such as race/ethnicity and gender identity;
- Education information, such as school name and grade level;
- Participation in activities and services, such as attendance dates and hours attended; and
- Anonymous and voluntary youth experience surveys.

DCYF and SFUSD will not publicly report any information that we provide in a way that may be used to identify your child (or you, if you are 18 years of age or older).

Restrictions: All information that we provide that is related to an SFUSD student is protected by federal and state laws that govern the use, disclosure, and re-disclosure of student education records. Parties other than DCYF and SFUSD will not have access to any personally identifiable information that we report, except to the extent that the parties have obtained prior written authorization from you or have followed SFUSD policies and procedures to obtain access to such information.

Expiration: This authorization expires on June 30th, 2023 .

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing our agency in writing. If you cancel your permission allowing us to release information to DCYF and SFUSD, it will go into effect immediately, unless the information has already been released. You have a right to receive a copy of this form.

Your Name: _____

Relationship to Participant: ☐ Parent ☐ Legal Guardian ☐ Participant 18 Years of Age or Older

Signature:_____ Date: _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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
*Must reflect the same names as above.	

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

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

PLEASE SIGN AT THE BOTTOM

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)

Stonestown YMCA- Dianne Feinstein ES . This Child Care Center/School provides a program which extends from 1 : 30
(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: _____
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.

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

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

Stonestown Family YMCA- Dianne Feinstein ES
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

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

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)
Stonestown Family YMCA- Dianne Feinstein	2550 25th Avenue, San Francisco CA 94116

(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: 801 Traeger Avenue Suite 100

   Licensing Office Telephone #: San Bruno CA 94066

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.

Stonestown Family YMCA- Dianne Feinstein ES
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