Early Education Services
University of California, Santa Cruz
Mail Stop: EES
599 Koshland Way
Santa Cruz, CA 95064

WELCOME TO EARLY EDUCATION SERVICES!

In order for your child(ren) to be prepared for enrollment, the following forms MUST be completed and returned to our office or mailed to the address on the top of the page. All documents must be submitted to our office before care can begin:

_____ Your child(s) **Physician's Report.** (Infant and Preschool only)

_____ A copy of your child's most updated **immunization record**. 

_____ The enclosed **Child Emergency Information Form**. 

_____ The enclosed **Consent For Emergency Medical Treatment Form**.

_____ The enclosed **Meal Benefit Form**. 

_____ The enclosed **Infant Meal Notification** (Under 12 months only)

_____ The enclosed **Sunscreen Permission Form.** 

If you have any questions about the required documents, please contact LeeAnn O'Connell at loconnel@ucsc.edu or Sohyla Fathi at ksfathi@ucsc.edu or come by the office during the business hours noted above.

EES Team

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:_____ 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.

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
( )	( )

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

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

MEAL BENEFIT FORM FOR CHILDREN
YEAR 2012-2013

Name of Child Care Center: **Early Education Services**

Please read the instructions. If you need help completing this form call: **831-459-3396**

Complete, sign, and return the form to: **LeeAnn O'Connell at the EES Business Office**

1. **CHILD INFORMATION**
(List names of all children enrolled for care)

Check if a foster child (the legal responsibility of a welfare agency or court).

If all children listed below are foster children, go to #4 to sign this form.

Last **First** **M.I.**	
1.	☐
2.	☐
3.	☐
4.	☐

2. **BENEFITS:** If you are getting CalFresh, CalWORKs, FDPIR, or Kin-Gap benefits for your child, list the case number, and DO NOT complete #3. Go to #4.

CalFresh Case Number:
CalWORKs Case Number:
FDPIR Case Number:
Kin-GAP:

3. **ALL OTHER HOUSEHOLD MEMBERS:** Complete this section if you DID NOT complete #2. List all household members. List all income. Go To #4.

NAMES	**CURRENT INCOME**			
NAMES OF HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	**EARNINGS FROM WORK BEFORE DEDUCTIONS**	**CALWORKS, CHILD SUPPORT, ALIMONY**	**PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY**	**EARNINGS FROM ANY OTHER INCOME**
Example: *Jane Smith*	*$200 / weekly*	*$150 / every 2 weeks*	*$100 / twice a month*	*$50 / monthly*
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$
6.	$	$	$	$
7.	$	$	$	$
8.	$	$	$	$

4. **LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE:**

PENALTIES FOR MISREPRESENTATION: *I certify that all of the above information is true and correct and that the CalFresh, CalWORKs, FDPIR, Kin-GAP, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.*

Printed Name:	
Last Four Digits of SSN: ☐ Check here if no SSN	
Signature of Adult:	Date:

Privacy Act Statement: Unless you list the child's CalFresh, CalWORKs, FDPIR or Kin-GAP case number, Section 9 of the National School Lunch Act (NSLA) requires that you include the last four digits of the SSN for the household member signing the form, or indicate that the household member signing the form does not have a SSN. You do not have to list the last four digits of a SSN, but if they are not listed, or the "Check here if no SSN" is not marked, we cannot approve your child for free or reduced price meals. The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, FDPIR, or Kin-GAP office to determine current certification for CalFresh, CalWORKs, FDPIR, or Kin-GAP benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. **RACIAL/ETHNIC IDENTITY:** You are not required to answer these questions. If you choose to do so, please mark one or more of the following **racial** identities:

☐ American Indian or Alaska Native ☐ Asia ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Please mark one of the following **ethnic** identities: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339, or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

For Agency Use Only	
CATEGORICAL ELIGIBILITY	
CalFresh/CalWORKs/ FDPIR/ Kin-GAP household categorically eligible free: ☐ Yes ☐ No	
Foster child automatically eligible free: ☐ Yes ☐ No	
INCOME ELIGIBILITY Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12	
Total annual income: Household size:	
Eligibility classification: ☐ Free ☐ Reduced Price ☐ Base	
Determining official (print name):	
Signature:	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the Meal Benefit Form to: **LeeAnn O'Connell at the EES Business Office.**

If you need help, call: **831-459-3396**

1. **CHILD INFORMATION:**
   a) Print your child's name.
   b) Check box to right of name if a foster child.
   c) Include the name of the child care center.

2. **BENEFITS:** Complete this section and sign the form in #4.
   a) List your current CalFresh, CalWORKs, FDPIR or Kin-GAP case number(s) for your child(ren).
   b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. **ALL OTHER HOUSEHOLDS:** Complete this section and sign the form in #4.
   Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**
   a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, CalWORKs, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
   b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
   c) Sign the form and include the last four digits of your SSN in #4. *If you do not have a SSN, check the box "Check here if no SSN."*

4. **LAST FOUR DIGITS OF SSN AND SIGNATURE:**
   a) The form must have a **signature** of an adult household member.
   b) The adult household member who signs the statement must include the last four digits of his/her **SSN**. *If he/she does not have a SSN, check the box "Check here if no SSN".* The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, FDPIR, or Kin-GAP case number.

5. **RACIAL/ETHNIC IDENTITY:** You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work:
- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

CalWORKs/Child Support/Alimony
- Public assistance payments
- CalWORKs payments
- Alimony/child support payments

Pensions/Retirement/Social Security
- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income
- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino

Infant Meal Notification

Child Care Center Name: Early Education Services
Iron-fortified Infant Formula Offered by Center: Earth's Best Organic

All children enrolled in this center, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Child care centers in the program are reimbursed to help with the cost of serving nutritious meals to enrolled children. The meals must meet CACFP nutrition guidelines for children and infants. To meet CACFP requirements this center will provide formula and other foods for infants.

To help provide the best nutritional care for your infant, please complete the following information and return it to the center:

Infant's First and Last Name:	Infant's Date of Birth:

I understand that the child care center will supply the above iron-fortified infant formula for infants according to the CACFP requirements. *Note: Child care centers may request parents to supply clean, sanitized, and labeled bottles on a daily basis.

If you formula-feed your infant, place a check mark by only ONE of the following:

□ I prefer to have the child care center supply formula OR
□ I will supply formula for my infant.

If you breastfeed your infant, place a check mark by only ONE of the following:

□ I will supply expressed (pumped) breastmilk. OR
□ I will supply expressed (pumped) breastmilk and have the child care center supply formula to supplement as needed. OR
□ I will supply expressed (pumped) breastmilk and will supply formula to supplement as needed.

I understand the child care center will supply infant cereal and other foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements. Infant foods include fruits/vegetables, meat/meat alternatives, enriched bread or snack crackers, and 100% full strength juice that are creditable to the USDA Infant Meal Pattern.

Place a check mark by only ONE of the following:

□ I prefer to have the child care center supply infant cereal and infant foods. OR
□ I will supply infant cereal and infant foods for my infant.

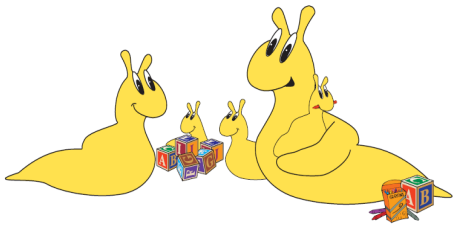
*This facility has not requested or required me to provide infant formula or food for my infant. I understand that I have the choice of having my infant participate in the CACFP.

Parent/Guardian Signature _____ Date _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

UCSC Early Education Services

Permission to Apply Sunscreen



Child's Name_____

Parent/Guardian's Name_____

I give my authorization for UCSC Early Education Services staff to apply sunscreen provided by the Center with UVB and UVA protection of SPF 15 or higher to exposed skin.

_____ _____

Parent/Guardian's Signature Date

I will provide the sunscreen, as described above, and authorize the Center to only apply the sunscreen I have provided.

_____ _____

Parent/Guardian's Signature Date