

IDENTIFICATION AND EMERGENCY INFORMATION -DAY CARE CENTERS

To be completed by a parent or guardian.

| | | | |
|--|---------------------------------|-----------------------------|--|
| Child's Name - First, Middle, Last | | Birthdate | Sex |
| Parent/Guardian 1 Name - First, Middle, Last | | P1 First Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| <input type="checkbox"/> Sole Custody <input type="checkbox"/> Shared Custody | Parent/Guardian 1 Email Address | P1 Second Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Address Where Child Resides City State Zip | | P1 Third Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Parent/Guardian 2 Name - First, Middle, Last | | P2 First Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| <input type="checkbox"/> Sole Custody <input type="checkbox"/> Shared Custody | Parent/guardian 2 Email Address | P2 Second Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Parent/Guardian 2 Address, if different City State Zip | | P2 Third Call Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |

ADDITIONAL PERSONS WHO MAY BE CALLED IN EMERGENCY

Provide at least three LOCAL contacts.

| | | | |
|------|--------------|--------------|--|
| Name | Relationship | Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Name | Relationship | Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Name | Relationship | Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |
| Name | Relationship | Phone Number | Type <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> O |

ADDITIONAL 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 GUARDIAN)

| | |
|------|--------------|
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |

PHYSICIAN AND DENTIST TO BE CALLED IN AN EMERGENCY

| | | |
|-----------|----------|--------------|
| Physician | Address: | Phone Number |
| Dentist | Address: | Phone Number |

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN

| | |
|------------------------------|------|
| Signature of Parent/Guardian | Date |
|------------------------------|------|

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR

| | |
|-------------------|---------------------|
| Date of Admission | Date of Termination |
|-------------------|---------------------|

NAME:

Quail Hollow Montessori

Enrollment Form Checklist

Identification and Emergency Information (Copy to Briana)

Allergy/Food Restriction _____

Emergency Medical Consent _____

Field Trip Release _____

Admission Agreement (Copy to Briana)

Child's Pre-admission Health History (lic 702)

Physician's Report _____

Immunization Record (Copy to Briana)

Parents Rights _____

Personal Rights _____

New Child Classroom Information Sheet _____

Sunscreen Permission Form _____

Two Week Notice Contract _____

Discipline Policy _____

Receipt of Parent Handbook _____

Parent Questionnaire _____

Napsack Form (if applicable) _____

Routine Physical Contact _____

Classroom Rules _____

Infant Supplement _____

Electronic Statements Notice _____

Credit Card Billing Form (Give to Briana)

Application Form (Copy to Briana)

Directory Participation (Copy to Briana)

Permission to Sign In _____

Text Communication Form _____

Health and Social Distancing Policies _____

☐

copy for emergency binder

Quail Hollow Montessori

First Day Checklist

**Please remember to bring the following items on
your child's first day!**

Photo of child's face - approximately 1.5" X 2"

Healthy Lunch. For infants -all food/bottles for the day

Extra clothes, labeled and placed in a ziploc baggie.

Diapers or pull-ups, if your child uses them,
marked with initials.

6 cans of meat or vegetables for emergency supplies

Face mask (for children 3 and up)

reusable bag or backpack for carrying personal items

Any forms and fees not yet turned in

Nap Linens

Preschool and Toddler

a nap sack will be assigned. Please wash it once a week.

Bring a crib sized sheet labeled with your child's name.

You may also provide a small pillow or stuffed animal.

Infants

Infants should have a crib sheet for each
day that they will attend. (This is a licensing regulation.)

Infants need a small blanket or sleep sack. They can have
a pacifier or comfort toy or blanket if your child uses one.

ALL ITEMS MUST BE LABELED!

Allergies and Dietary Restrictions

Child's name _____ Date _____

- Does your child have any allergies? ☐ Yes ☐ No

| Allergy | Severity mild, medium, severe, epi-pen |
|---------|---|
| | |
| | |
| | |
| | |

- Does your child have any dietary restrictions?

- If your child has food allergies or dietary restrictions, we recommend you provide your child's snack.

_____ I decline to provide snack and relieve SVCC from all liability if my child mistakenly ingests above noted foods.

Parent's name _____

Parent's signature _____ Date _____

=====

ACKNOWLEDGEMENT OF RECEIPT OF PARENT HANDBOOK

I acknowledge that I have been given a copy of the Quail Hollow Montessori (QHM) Parent Handbook. I understand that this handbook summarizes QHM's policies, practices and participation guidelines and that it is furnished to me solely for my information. I also understand that QHM may at any time modify or rescind any of its policies and/or practices described in the handbook, except for those policies and/or practices required by law. I acknowledge that it is my responsibility to read and become familiar with the contents of this handbook.

Dated: _____

By: _____
Signature

Printed Name of Parent (or Legal Guardian): _____

Parent Handbook, Yr _____

=====

Quail Hollow Children's Center Field Trip Authorization Form

I, _____ give permission for my child, _____
(Parent's Name) (Child's Name)
to attend all scheduled field trips with Quail Hollow Children's Center. I understand that if transportation is required, the means for transportation will be either Quail Hollow Children's Center insured staff members or insured volunteers with personal autos. The destinations will be posted near the sign-in sheets prior to any trip. I understand that I will need to sign for approval to participate for each field trip separately in addition to this form. Each child traveling in an auto will always be secured by a seat belt in an appropriate car seat. I will leave my child's car seat at the school to be used on the day of a field trip.

Parent/Guardian's Signature

Date

Emergency Contact Numbers:

name

number

name

number

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

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

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

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

| | | |
|--|--|------------|
| CHILD'S NAME | SEX | BIRTH DATE |
| FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? | |
| MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? | |
| IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION | |

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

| | | | | | |
|------------|--------|-------------------|--------|-----------------------------|--------|
| WALKED AT* | MONTHS | BEGAN TALKING AT* | MONTHS | TOILET TRAINING STARTED AT* | MONTHS |
|------------|--------|-------------------|--------|-----------------------------|--------|

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

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

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| | | |
|--|------------------------|---|
| DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?* | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* | WHAT IS USUAL TIME?* |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| WORD USED FOR "BOWEL MOVEMENT"* | | WORD USED FOR URINATION* | |

PARENT'S EVALUATION OF CHILD'S HEALTH

| | | | |
|--|-------------------------|--|---|
| IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DOES CHILD USE ANY SPECIAL DEVICE(S): | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? | IF YES, WHAT KIND: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

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

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)

Quail Hollow Montessori This Child Care Center/School provides a program which extends from 7 : 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/ (DIPHTHERIA, TETANUS AND DT/Td (ACELLULAR) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY) | / / | / / | / / | / / | / / |
| MMR (MEASLES, MUMPS, AND RUBELLA) | / / | / / | | | |
| (REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (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.

****Physician - please be sure to check the appropriate TB risk factor box!**

Fax Back to Quail Hollow Montessori
831-464-1408

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

**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: 2580 N. First St., Suite B, San Jose, CA 95131

Licensing Office Telephone #: 408-324-2148

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.

Quail Hollow Montessori

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

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

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

LIC 995 (9/08)

IMPORTANT INFORMATION**CAREGIVER BACKGROUND CHECK INFORMATION**

The law requires that the Community Care Licensing Division check the criminal background of all adults who apply for a license to operate a community care facility. We also check the criminal background of all adults who want to work, reside in or have contact with clients being cared for in a community care facility.

What is a background check?

As part of the background check process you must be fingerprinted and tell whether you have ever been convicted of a crime other than a minor traffic violation. The Department of Justice and the FBI will check your fingerprints against their criminal record information. If you will have contact with children, your name will be checked against the Child Abuse Central Index registry. This is a listing of people who have been reported for suspected child abuse. If you have not been convicted of a crime and have no child abuse history, you will be given a "clearance."

What if I have a criminal conviction?

If you were ever convicted of a crime, other than a minor traffic violation, even if it happened a long time ago, you cannot own, live or work (including some volunteers) in a facility unless we give you an "exemption." If the Department of Justice notifies us that you were convicted of a crime, we will notify the facility operator that an exemption is needed. If you were convicted of a serious crime or if you are on supervised probation after being convicted of a crime, you probably won't be given an exemption.

You do not qualify for a criminal record exemption if you have ever been convicted of a serious crime such as robbery, sexual battery, child abuse, elder or dependent adult abuse, rape, first degree burglary, arson, or kidnapping. These kinds of crimes are **nonexemptible** and if you were convicted of one of them, by law you will never be allowed in a facility.

How do I get a criminal record exemption?

As part of the request for an exemption, the facility operator or you must send us convincing proof that you are of good character in spite of your conviction. We will review any information you submit as well as the number and type of crimes committed, how long ago the crime(s) happened, what kind of work you will be doing and whether you will be working with children, adults, or the elderly. *(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)* If we find that you were not truthful in the information you submitted for your exemption, we will deny your exemption request. In most cases, if you are currently on supervised probation or on parole you will **not** be granted an exemption. If your exemption is denied, and you are married to or living with someone who is applying for a license and care will be provided in your home, his or her application will be denied because everyone who lives in the home must have a clearance or exemption. If a criminal record exemption is granted to you and you later move, or want to work in a different facility, your exemption will be re-evaluated based on your new role and our current laws, regulations, and policies. If you are arrested or convicted after an exemption is granted to you, your exemption may be cancelled. If you are married to or living with someone who is licensed, and care is provided in your home, the facility license may be suspended or revoked.

You are strongly encouraged to read the licensing criminal record exemption regulations to find out the amount of time that must pass following your conviction, before you can qualify for an exemption. Some convictions require longer periods of time following conviction than others. The regulations and other information can be found on our web site at www.cdld.ca.gov.

How long does the criminal record exemption process take to complete?

If you do not have a criminal record, a clearance is normally available in a few days. If an exemption is needed, it may take three months or longer to complete the process.

**DISCLOSURE OF CRIMINAL RECORD EXEMPTION INFORMATION
UNDER THE CALIFORNIA PUBLIC RECORDS ACT**

If you are granted a criminal record exemption, your name will be given out to the public, upon request. If you own a facility and you have staff, residents or volunteers who have a criminal record exemption, the name of your facility will be given out to the public, upon request.

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 | | |
| 111 N. Market St., Suite 300 | | |
| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
| San Jose | | 408-324-2148 |

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) |
| Quail Hollow Montessori | 187 Laurel Dr., Felton, CA 95018 |
| (PRINT THE NAME OF THE CHILD) | |
| (SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | |
| (TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | (DATE) |

NEW CHILD ENROLLMENT CLASSROOM INFORMATION SHEET

CHILD'S NAME _____ AGE _____

CHILD'S HOME ADDRESS _____

BIRTHDAY _____ HOME PHONE _____ PETS? _____

MOMS NAME _____ BIRTHDAY _____ WORK # _____

MOMS WORKPLACE _____

DADS NAME _____ BIRTHDAY _____ WORK # _____

DADS WORKPLACE _____

LIVES WITH (circle): MOM DAD BOTH OTHER _____

SIBLINGS: _____ AGE _____ SCHOOL _____

SIBLINGS: _____ AGE _____ SCHOOL _____

SIBLINGS: _____ AGE _____ SCHOOL _____

OTHER FAMILY _____

WHAT HOLIDAYS/EVENTS DOES YOUR FAMILY CELEBRATE AND HOW? _____

HAS THE CHILD BEEN IN A PRESCHOOL SETTING BEFORE? _____

MEDICAL HISTORY _____

ALLERGIES? _____

PERSONALITY _____

FAVORITE TOY/BLANKET? _____

TEACHER _____ CLASS _____

FIRST DAY _____ TIMES ATTENDING _____

| DAYS ATTENDING: | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|-----------------|--------|---------|-----------|----------|--------|
| | AM | AM | AM | AM | AM |
| | PM | PM | PM | PM | PM |

REMARKS: _____

PARENT'S PERMISSION FORM
SCHOOL-SUPPLIED SUNSCREEN (April 2017)

Quail Hollow Montessori
325 Marion Ave.
Ben Lomond, CA 95005

Child's Name: _____

I give permission for childcare providers employed by Quail Hollow Montessori to administer "Rocky Mountain Kids Sunscreen, Broad Spectrum, SPF 30" to my child as deemed necessary. Adverse reactions to this sunscreen will be reported in writing to the parent and parent will be requested to supply an alternative sunscreen product. Parents are required to apply sunscreen before dropping children off at school in the morning.

If you do not give permission to use school supplied sunscreen, please provide us with an unopened container of your preferred sunscreen with your child's name written permanently on it.

Parent's Signature

Date

Parent's Name (please print)

Quail Hollow Children's Center
Two Week Notice Contract

I, _____ am enrolling my child, _____
(Parent's Name) (Child's Name)
in the Quail Hollow Children's Center. I understand that this program requires a two week written notice for any program changes; i.e. attendance changes of time, day, additions, deletions or program withdrawal.

My two week notice allows Quail Hollow Children's Center administrative staff to respond to my request. In the case of program withdrawal, it gives the program time to place another family in the space I am leaving or changing from. I understand how important it is that the program be given notice of changes and agree to give written notice of two weeks on any schedule change.

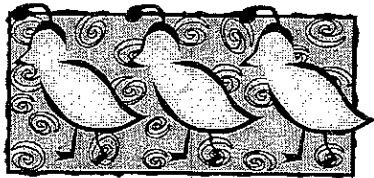
I understand that if I withdraw without any notice, any outstanding credits to my account will not be refunded. If I provide two week written notice, any credit to my account at the end of the two weeks will be refunded within 10 days of my child's final day of attendance by administrative staff.

Parent/Guardian's Signature

Director's Signature

Date

Quail Hollow



Montessori

Discipline Policy and Behavior Guidance

Our staff will provide each child with guidance that helps the child acquire a positive self-concept. Discipline and behavior guidance used by each caregiver will always be constructive, positive and suited to the age of the child. The following rules and standards will apply in the center for preschool children. (Infants are not disciplined.)

1. To prevent unacceptable behavior from occurring, the staff will:
 - a. Model appropriate behavior for the children
 - b. Arrange the classroom environment to enhance the learning of behaviors that are acceptable.
 - c. Use descriptive praise when appropriate behavior is occurring (for example: "Look how well you are cleaning up after yourself.")
2. When unacceptable behavior is about to occur or is occurring, the staff will use:
 - a. Redirection: substituting a positive activity for a negative activity.
 - b. Distraction: change the focus of the activity or behavior
 - c. Active Listening: to determine the underlying cause of the behavior
 - d. Loss of Freedom: child will be required to stay with a teacher for a short time until behavior improves.

The program complies with all federal, state and local laws which prohibit corporal or abusive punishment in child care settings. Staff members are strictly prohibited from using unproductive or shaming methods of punishment.

Quail Hollow Montessori believes that parents and child care staff must work together to deal with persistent behavioral issues such as biting, or unusual or dangerous aggression to self or others. If a child appears to be unusually stressed, anxious or otherwise motivated to engage in negative behaviors, the parents will always be consulted.

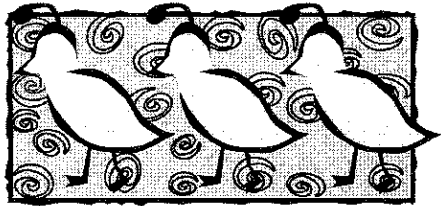
I have read and understand the explanation of Quail Hollow Montessori's discipline methods.

Parent/Guardian Signature

Date

Quail Hollow Montessori 187 Laurel Dr., Felton CA 95018
Mailing Address: 255-B Mt. Hermon Rd., Scotts Valley, California 95066
Telephone: (831) 335-4710 Facsimile: (831) 335-4703 Email: qhpreschool@comcast.net

Quail Hollow



Montessori

Nap Sack Contract

In order to meet licensing regulations, which require that each child's napping linens stay entirely within their own cubby and do not touch any other children's' linens, we will assign a "nap sack" for children who stay at school for nap. The nap sack is a small polar fleece sleeping bag that rolls up into a small cylinder. You may provide a small pillow with a washable cover and a small favorite nap companion, like a stuffed animal. Please **DO NOT** send your child with a large pillow, large stuffed animal or large blanket as these items will not fit in the cubby.

Nap sacks must be taken home and washed at the end of each week and returned on the child's next day of attendance. **LABEL ALL LINENS AND PERSONAL ITEMS.**

Linen Fee: If you forget your child's nap sack, we can provide a loaner. You will be charged a fee of \$1 per day that QHM provides a loaned nap sack for your child to offset laundering costs. **You will be charged a \$25 deposit which will be forfeited if your child's nap sack is lost or destroyed.**

Nap Sack Policy Acknowledgment

Child's Name: _____ Nap Sack Number _____

I have read the nap linen policy above and I understand that I am responsible for washing the nap sack each week. I understand that a \$25 deposit will be charged to my account and will be refunded when the nap sack is returned in good condition.

Parent's Signature _____

QUAIL HOLLOW MONTESSORI

CLASSROOM RULES

Our classroom rules are designed to protect children's rights and safety.

Please be familiar with them and review them with your children.

Children use "Outside Voices" outside and "Inside Voices" inside.

Children will be stopped from hitting, kicking, pushing, shoving, biting or sand throwing at anyone. Running jumping is for outside, unless part of a teacher directed activity.

Children go outside to the playground only when accompanied by a teacher.

Children may not climb furniture, shelves, fences or dangerous places.

Blocks are for building, not throwing. Toys and supplies are not to be thrown (unless intended for that purpose).

We don't allow name calling, cruel teasing or verbal abuse.

Destruction of school property or friends' belongings will not be tolerated.

Weapon play and violent play is not allowed at school.

Eating will be at tables only. We don't walk around with food or drinks.

Preschool Sharing Days vary by classroom. Children may bring an education item related to our learning themes of the month to show their friends. No toys please.

Security items (stuffed animal, doll, etc.) are acceptable at school for use only at nap time. As a rule, all home toys should remain at home.

Electronic Format for Newsletters and Statements

Quail Hollow Montessori provides monthly account statements and monthly newsletters in electronic format via email. Please be sure to provide your email addresses to the office. If you are not receiving monthly emails, we may have an incorrect email address for you.

Newsletters & Statements

I require a printed copy of statements Yes _____ No _____

I require a printed copy of the newsletters Yes _____ No _____

Community Directory

Quail Hollow Montessori provides a community directory.

Include me in the directory Yes _____ No _____

Include my email address Yes _____ No _____

Include my home phone number Yes _____ No _____

Child's name: _____

Parent/Guardian name: _____

Parent Signature _____

Date: _____

Credit Card Billing Form

KINSPIRATION, INC.

dba Scotts Valley Children's Center

dba Little Acorns Montessori

dba Quail Hollow Montessori

dba San Lorenzo Valley Quest Program

| | |
|--|---------------------------|
| Child's Name | Cardholder Phone Number |
| Card Holder Name | Date of First Transaction |
| Billing Address | Date of Last Transaction |
| Card Type (Visa/Mastercard) Card Number | Expiration Date |
| Minimum Transaction Amount Maximum Transaction Amount | |

I have enrolled my child in the Kinspiration, Inc. program for the center and schedule stated in the registration form. I would like to pay my program fees by credit card.

Credit card payments will be processed monthly on the 20th of the month (or the next business day, if the 20th falls on a weekend) of the month prior to care being provided. If I intend to terminate care, I understand that I must provide notice 10 business days prior to the next credit card transaction date (the 10th of the month or the next business day if the 10th falls on a weekend). Monthly fees transacted will follow the separately provided fee schedule based on your current enrollment schedule.

I have received the rate schedule and understand that this fulfills my right to written notice of upcoming transactions at least 10 days prior to the date of the next charge.

Cardholder Signature

Date

Parent's Questionnaire Quail Hollow Montessori

Name of Child _____

1. What skills, talents, hobbies, interests or activities do you have that you might share with the children? _____

2. What do parents do for a living?

Can we use you as a resource for information and/or real life equipment or tools?

3. We'll be looking for lots of diverse materials to use in the classroom. As we feature different parts of the world during the year we will be looking for books, music, art, objects, toys, clothing etc. that represent cultures of the world. Do you have anything you would be willing to share, loan or even donate?

4. What is your family's ethnic/cultural background? (Optional – this is used because the family's are a wonderful source of cultural information and education for the children.) _____

5. Are there special foods that are representative of your ethnic/cultural background? Y N

Would you be willing to talk about and share a sample of one of your foods with the children at circle time? _____

6. List the most common holidays celebrated in your immediate family, and briefly describe how you celebrate.

HOLIDAY

HOW CELEBRATED

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7. What languages are spoken in your home?

What is your primary language?_

What is your child's primary language?

Does you child speak or understand another language?

8. What would you like to see your child learn about here?

PERMISSION TO SIGN-IN CHILD

CHILD'S NAME: _____

I give permission for employees of Kinspiration Inc., (Little Acorns Montessori, Quail Hollow Montessori, Coast Redwoods Montessori) to meet my child outside of the facility and to sign him/her in or out to the preschool program, as applicable, to allow restricted access drop-off and pick-up policies.

Signature: _____

Date: _____

Name(printed) _____

Text Messaging Service

Child's Name: _____

Quail Hollow Montessori has a student management system that can send bulk text messages. We will only use this feature in a situation where timely communication is very important. In order for the system to work we require both cell phone numbers and the service carriers. To be sure that you will receive important school text messages, please provide cell phone number and carrier information.

| Parent/Guardian Name | 10 Digit Cell Number | Cell Service Provider |
|----------------------|----------------------|-----------------------|
| | | |
| | | |
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| | | |

By signing below, you agree to receive text messages from Quail Hollow Montessori. Your cell service fees may apply.

Parent/Guardian Name

date