FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF SAN DIEGO COUNTY
2016 - 2017 LICENSED PROGRAM REGISTRATION CHECKLIST

CHILD'S NAME	SCHOOL/PRESCHOOL

ALL REGISTRANTS

- ☐ Registration Fee or Family Membership
- ☐ Licensed Program Registration (2 pages)
- ☐ Licensed Program ATS Application
- ☐ LIC 700 Identification and Emergency Information
- ☐ LIC 702 Child's Preadmission Health History
- ☐ LIC 613A Personal Rights
- ☐ LIC 627 Consent for Emergency Medical Treatment
- ☐ LIC 995 Notification of Parents' Rights
- ☐ LIC 9221 Parent Consent for Administration of Medications (If Applicable)*

*If your child requires incidental medical services (such as epi-pen or inhaler) additional forms must be completed prior to enrollment.

ADDITIONAL FOR INFANT/TODDLER/PRESCHOOL REGISTRANTS ONLY:

- ☐ LIC 701 Physician's Report
- ☐ Lead Blood Test
- ☐ Immunization Records

IN ORDER FOR YOUR CHILD TO ATTEND, ALL FORMS LISTED ABOVE NEED TO BE COMPLETED AND TURNED IN.

FOR OFFICE USE ONLY

I have received all documents listed above.

Staff's Name:_____ **Date Received:**_____

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YMCA OF SAN DIEGO COUNTY
2016-2017 LICENSED PROGRAM REGISTRATION

CHILD'S NAME	GENDER (M/F)	BIRTH DATE	GRADE
SCHOOL/PRESCHOOL		CLASS ROOM #	PROGRAM START DATE
PARENT/GUARDIAN NAME		PHONE NUMBER	EMAIL ADDRESS
PARENT/GUARDIAN NAME		PHONE NUMBER	EMAIL ADDRESS

ALLERGIES/DIETARY RESTRICTIONS
The safety of your child and other children in the classroom is our top priority. Please check all that apply.

☐ INSECT STING ☐ HAY FEVER ☐ INSECT STING
☐ PENICILLIN ☐ GLUTEN ☐ OTHER:_____
☐ NUTS:_____

CONDITIONS REQUIRING CONSIDERATION
The safety of your child and other children in the classroom is our top priority. Please check all that apply.

☐ ADD/ADHD ☐ ASTHMA ☐ BLEEDING DISORDERS
☐ DIABETES ☐ SEIZURES ☐ OTHER:_____

SELECT ONE OF THE FOLLOWING MONTHLY PLANS:

☐ Monday-Friday 700am-600pm ☐ **Participant $** 1,330 ☐ **Family Member $** 1,130 **Days your child will attend:** ☑ M ☑ Tu ☑ W ☑ Th ☑ F	

INITIAL ATTENDANCE AND FEE SCHEDULE
In order to register your child for one of our programs, you will need to have all forms completed and be prepared to pay the registration fee and first month's tuition. The registration fee is $50 and is waived with a family membership.

ACKNOWLEDGMENTS – Please read and initial each item below

Parent/Guardian Initials	I have received the Family Handbook and I am responsible for reading and abiding by the Policies and Procedures as set forth by the YMCA.
Parent/Guardian Initials	Monthly payments are made via Automatic Transfer System (ATS) on the 10th (for checking accounts) or the 15th (for credit cards). Notification of changes or corrections must be made to information on file by the 1st of each month in writing via an ATS Form. A $ 10 service fee will be applied for accounts returned unpaid, closed or payments stopped. I understand that it is my responsibility to notify the YMCA.
Parent/Guardian Initials	Cancellations are required in writing, 30 days prior to your child's last day in the program. Failure to do so will result in financial responsibility for payment. No refunds are given. I understand that I am required to give 30 days written notification to withdraw from the program.
Parent/Guardian Initials	I understand that I am responsible for ensuring my child is signed in and out of the facility by an authorized adult (18+ years old) on a daily basis.
Parent/Guardian Initials	I understand that, after completing registration, it will take 48 hours before my child can begin attending the program.

I understand all the policies and procedures in the YMCA of San Diego County 2016-2017 Licensed Program Registration.

Parent/Legal Guardian Signature _____ **Date** _____

YMCA RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT FOR MINORS

Name of Minor(s) _____

I, the undersigned parent/person having legal custody/guardianship of the above said minor, give permission for the minor to participate in all YMCA programs. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program.

In consideration of said minor being permitted to enter any branch of the YMCA of San Diego County ("YMCA") for observation, use of facilities and/or equipment, or participation of the above in any program, I, on behalf of myself (as parent, guardian, coach, aide, spectator or participant) hereby:

1. Acknowledge that (i) I have read this document, (ii) I have inspected the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document.

   Except for YMCA's gross negligence or willful misconduct I release the YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me or the above said minor, for any loss or damage to property or injury or death to person, whether said damage or injury results from conditions arising upon the YMCA facilities or arising out of or in connection with YMCA programs or activities. YMCA shall not be liable for any damages arising from any act or neglect of any other member, occupant or user of the YMCA premises or participant in YMCA programs or activities. I agree that the above said minor assumes full responsibility for, and risk of, bodily injury, death or property damage except caused or due to the gross negligence or willful misconduct of the YMCA.

2. I agree not to sue Releasees for any loss, damage, injury or death described above and except for YMCA's gross negligence or willful misconduct, I will indemnify, protect, defend and hold harmless the YMCA and its Releasees from and against any and all claims and/or damages, liens, judgments, penalties, attorneys' and consultants' fees, expenses and/or liabilities arising out of, involving, or in connection with, the YMCA membership, use of YMCA facilities and/or participation in YMCA programs by me, the above said minor or any other person. If any action or proceeding is brought against YMCA by reason of any of the foregoing matters, I shall upon notice defend the same at my expense by counsel reasonably satisfactory to YMCA and YMCA shall cooperate with me in such defense. YMCA need not have first paid any such claim in order to be defended or indemnified.

3. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care.

I intend this document to be as broad and inclusive as is permitted by the laws of the State of California; if any portion hereof is held invalid, I agree the balance shall continue in full force and effect.

Parent/Legal Guardian Signature _____ **Date** _____

Waiver/Consent

I,_____ give my permission to the YMCA of San Diego County (YMCA) to use my picture or other likeness, or a picture or other likeness of any of my children, specifically, _____, in the YMCA's general publicity and campaign materials.

Signature _____ **Date** _____

The YMCA of San Diego County is dedicated to improving the quality of human life and to helping all people realize their fullest potential as children of God through the development of the spirit, mind and body.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF SAN DIEGO COUNTY
LICENSED PROGRAM ATS APPLICATION

CHILD'S NAME	BIRTH DATE
SCHOOL/PRESCHOOL	
PARENT NAME(S)	

PAYMENT INFORMATION

CHECK OR CARD ACCOUNT HOLDER'S NAME(S)	
CREDIT CARD NUMBER	EXPIRATION DATE
BILLING ADDRESS (STREET NUMBER, STREET NAME, CITY, STATE, ZIP CODE)	
HOME PHONE | CELL PHONE	WORK PHONE
EMAIL ADDRESS	

Automatic payments occur monthly. Checking accounts on the 10th and credit/debit cards accounts on the 15th.

Please Initial:_____

Changes to automatic payments must be submitted in writing and at least 30 weeks/days prior to draft date.

Please Initial:_____

I hereby authorize the YMCA of San Diego County to initiate debits to the bank/credit account attached. This authority is to remain in full force and effect until the YMCA or BANK has received the 30 days written notification from me (us) of its termination in such a manner as to afford the YMCA or BANK a reasonable opportunity to act on it. A $ 10 service fee will be applied for accounts returned unpaid, closed, or payment stopped. I understand there are no refunds given. I understand it is my responsibility to check my monthly bank statement and report any corrections immediately to the YMCA.

Check or Card Holder's Signature:_____ **Date:**_____

FOR CHECKING ACCOUNT PLEASE ATTACH A VOIDED CHECK

DATE RECEIVED	DRAFT BEGIN DATE	FIRST MO. DRAFT FEE	DRAFT DATE	ENTERED CCC	ENTERED EXCEL	COMMENTS

NOTES AND ADJUSTMENTS

ATTACH VOIDED CHECK HERE

YMCA OF SAN DIEGO COUNTY
3708 Ruffin Road, San Diego CA 92123 | 858-292-9622

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

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER 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

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

7575 Metropolitan Way Suit 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Diego	92108	

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)
La Jolla YMCA	

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

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

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

La Jolla YMCA
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 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: 7575 Metropolitan Dr. Suite 110, San Diego, CA 92108

   Licensing Office Telephone #: (619) 767-2200

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.

La Jolla YMCA
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

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: *Regulation Section 101221 requires the following information be on file.*

CHILD CARE CENTER NAME:	LICENSE NUMBER:	DATE:
La Jolla YMCA		

PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME	**DOSAGE**

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From _____ to _____ at _____ daily while in attendance.
BEGINNING DATE ENDING DATE TIME OF DAY

PARENT'S SIGNATURE:	DATE:

MEDICATION CHART
Staff Documentation of Medicine Administration

DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE

Upon completion, return medicine to parent or destroy, and place form in child's record.

STAFF	DATE

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)

_____. 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.

DAYCARE PROVIDER

CHILD BLOOD LEAD TEST COMPLIANCE FORM

In accordance with Section 54.1011 of the City of San Diego's Lead Hazard Prevention and Control Ordinance (effective May 9, 2008), all child care centers or employee operated child-care centers in the City of San Diego are required to collect evidence of a blood lead test for each new enrollment for children between the ages of six months and seven years of age inclusive. Proof of blood lead screening is to be provided prior to admission, but in no event later than thirty days after admission. Please use this form to have your physician verify the test was completed, and return it to our office.

A blood lead test can be conducted by your current health care provider, either using a capillary (finger prick) test or a blood draw. You can discuss with your physician the types of test they perform. Physicians who are interested in getting trained in the capillary draw method can contact the County Health Department at (619) 515-6576, or at (619) 515-6636. Costs are typically covered by most health care insurances. If you would like a listing of clinics that conduct finger prick testing, or more information about the ordinance and childhood lead poising prevention, contact the City of San Diego's Lead Safety and Healthy Homes Program at (858) 694-7000 or visit their website at www.leadsafeneighborhoods.org.

Parent or legal guardian: _____
Print Name

Address: _____
Street City Zip

Child's Name: _____ Date of Birth: _____

Physician use only

On _____ the above listed child was screened for lead poisoning
Date
in accordance with applicable criteria mandated by the State of California.

Physician: _____
Print Name

_____ _____ _____
Physician's Signature Date Phone#

Childhood lead poisoning is the greatest ***preventable*** environmental disease affecting children today. The highest risk is for children under six as their brains and nervous systems are still developing and are more sensitive to the damaging effects of lead. Medical research in the past five years identifies there is no safe level of lead exposure in children. The highest loss of intelligence quotient, an average of 7.3, occurs below the Center for Disease Control and Preventions level of concern of 10 micrograms of lead per deciliter of blood. Additional research in 2008 shows compelling evidence linking childhood lead poisoning to criminal activity later in life.