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/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

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
( )	( )

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: L.A. Day Care - East

   Licensing Office Address: 1000 Corporate Center Drive, Monterey Park California 91754

   Licensing Office Telephone #: (323) 981-3350

8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (8/08) (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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee. Pasadena Christian Preschool
Name of Family Child Care Home

Signature (Parent/Authorized Representative) _____ Date_____

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

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

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:

Dept. of Social Services - Community Care Licensing Division

NAME

Los Angeles Child Care East

ADDRESS

1000 Corporate Center Drive, Suite 200B

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterey Park	91754	(323) 981-3350

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)
Pasadena Christian Preschool	1485 North Los Robles Ave Pasadena CA 91104

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

Pasadena Christian Preschool Illness & Medication Regulations

For the health and safety of all students, teachers are required to perform a daily health check of all children. This is a check that will include visual observation, discussion with the parent/child, and taking temperatures. ***These health check steps will be repeated throughout the day as needed.***

ILLNESS

STATE REGULATIONS PROHIBIT day care facilities from having a child in attendance with **any** of the following conditions:

- If he/she has a known infectious or communicable disease.
- If he/she has a fever or had a fever during the **previous 24 hour period.**
- If he/she has heavy nasal discharge the facility **must** have a note from the child's pediatrician allowing him/her to attend school again.
- If he/she has been taking an antibiotic for **less than 24 hours.**
- If he/she has had **vomiting** or **diarrhea** in the last **24 hour period**. If the child has been sent home from school **there is a 24 hour waiting period before re-admittance.**
- If he/she has yellow, white or green discharge from their eyes.
- If he/she has a **constant** cough.
- If he/she has a cold
- If he/she has a new skin rash or mouth sores.
- Has active lice in the hair; children with lice or nits will be sent home and asked to see a lice removal specialist; proof of the visit will be required upon return to school. To prevent further outbreak, the school may, at its discretion, bring in a lice specialist check the hair of all students in that classroom.
- **PLEASE SEE OUR COVID-19 RESPONSE POLICY FOR COVID-19 SPECIFIC GUIDELINES**

Children may also be excluded from school at the discretion of the staff:
- If he/she is fussy, cranky, lethargic, and generally not her/himself

Your child may come to preschool:

- If his/her cold is over, but is left with a **minor** nasal drip.
- If he/she has been exposed to a communicable disease, a physician's note or call must be received in order to return.

The preschool reserves the right to ask for a physician's authorization to return to school. As a courtesy, please keep your child home even if he or she is just tired or not feeling well; rest at such times may prevent the development of serious illness.

COMMUNICABLE OUTBREAKS

If your child has been diagnosed or presents symptoms of a possible communicable disease, **you are required to notify the preschool office at once.** If two or more students present with a communicable disease (i.e. Hand Foot and Mouth, Chicken Pox, etc.), all parents will be notified via email.
PLEASE SEE OUR COVID-19 RESPONSE POLICY FOR COVID-19 SPECIFIC GUIDELINES

IMMUNIZATIONS

ALL students entering school MUST be current on all vaccinations as required by the State of California. A copy of each child's immunization form must be submitted prior to entering school.

Required immunizations are outlined here: http://www.shotsforschool.org/child-care/

If a child is on a delayed immunization plan, he or she will be excluded from school in the event of a communicable outbreak for which they are not vaccinated.

MEDICATIONS

All medications issued at school need to be presented to the preschool office for processing. Prescription and non-prescription medications may be given by school staff at the discretion of the school administration and under the following conditions:

Prescription Medication:

California Education Code Section 49423 provides that any pupil who is required to take medication during the regular school day prescribed by a physician may be assisted by the designated school personnel if the school receives:

(1) A written statement from the physician detailing the method, amount and time schedule by which such medication is to be taken. *Your physician must sign the PCS Administration of Prescription Medication form.*

(2) A written statement from the parent or guardian of the pupil indicating the desire that the school assist the pupil in the matter set forth in the physician's statement. *A parent or guardian must also sign the PCS Administration of Prescription Medication form.*

(3) All medication must be in a bottle labeled by the pharmacy with the student's name and name and dose of medication.

Non-Prescription Medication:

A parent or guardian must complete and submit to the office the Administration of Non-Prescription Medication form. Over-the-counter medication must be in the original labeled container and delineate instructions on issuance and dosage. **Our staff will <u>not</u> dispense over-the-counter medication, which includes cough drops, sunscreen, diaper ointment, antibiotic ointment, etc., without an Administration of Non-Prescription Medication Form on file.**

ILLNESS AT SCHOOL

Often, children are seemingly fine in the morning at drop-off but present with symptoms during the day. Children are required to go home if they present with any of the above-mentioned symptoms/conditions. The school also reserves the right to send a child home if they are *unusually* lethargic, cranky, or generally not him/herself.

When a child presents with symptoms, the child will be brought to the preschool office and the school will call the parents at once. If a parent cannot be reached, we will contact the next person on the child's emergency contact list.

It is our expectation that parents pick-up within a reasonable amount of time, generally 30 minutes or less. Please advise the staff if there are *extenuating circumstances* that may cause a delay of more than 30 minutes.

I have read and understand the Illness and Medication Regulations of Pasadena Christian Preschool and have a plan for care in the event my child is ill.

Child's Name: _____

Signature of Parent/Guardian: _____

Administration of Sunscreen, Lotion, & First Aid Medication Form
Duration: August 17th, 2022 – May 25th, 2023

Name of Student: _____Birthdate: _____ Room #_____

California state licensing mandates that all non-prescription/over-the-counter medications (including, but not limited to, lotions, ointments, liquids, tablets, pills, etc.) to be issued or applied at school be accompanied by a signed permission form. **If your child requires another non-prescription and/or prescription medication other than what is listed below, please request an "Administration of Medication Form" from the preschool office.**

Instructions:
ALL non-prescription medications, lotions, creams, ointments, pills, tablets, etc. **MUST be NEW in the SEALED, original, labeled container and brought in a Ziploc bag, labeled with your child's full name, birthdate and room number. Medication may not expire before the end of the summer program.**

If you would like our staff to apply or dispense any of the listed items below, please complete, sign, and return this form. All medications will be applied according to the manufacturer's instructions printed on the label.

FIRST AID MEDICATION – In the event of a minor first aid incident, I authorize the staff of Pasadena Christian Preschool to apply the following **school-issued** ointments if deemed appropriate/necessary by the attending staff member. These will be applied according to the manufacturer's instructions.

- ☐ Soap and Water Only
- ☐ **Triple Antibiotic Ointment** (Bacitracin Zinc 400; Neomycin Sulfate 5mg)
- ☐ **Antiseptic Towelette** (Benzylkonium Chloride)
- ☐ **Sting Relief Insect Bite Antiseptic & Pain Reliever** (Ethyl Alcohol 50%/Lidocaine HCl 2%)
- ☐ **Anti-Itch Cream** - itchy insect bites (1% Hydrocortisone)

Specific Instructions (if any):

SUNCSCREEN/LOTION – I authorize the staff of Pasadena Christian Preschool to apply sunscreen to my child if deemed advisable or appropriate, or according to my specific written instructions below.

- ☐ School Issued Sunscreen (*Banana Boat 50+*)
- ☐ School Issued Lotion (*Aveeno Daily Moisturizing*)
- ☐ Parent Issued Sunscreen
- ☐ Parent Issued Lotion
- ☐ I do **NOT** authorize the school to administer sunscreen or lotion.

Specific Instructions (if any):

DIAPERING – I authorize the staff of Pasadena Christian Preschool to apply the following ointments if deemed appropriate/necessary by the attending staff member, and/or per my written instructions.

- ☐ School Issued Diaper Rash Cream
- ☐ Parent Issued Diaper Rash Cream
- ☐ Not Applicable

Specific Instructions (if any):

If your child requires any other non-prescription or prescription medication, please complete an Administration of Non-Prescription Medication Form or Administration of Prescription Medication Form available through the preschool office.

I request that the school assist my child in taking/applying the above referenced medication.

Signature of Parent: _____ Date: _____

Printed Name of Parent: _____

Date: _____

Parent Consent for Administration of PRESCRIPTION Medication

Name of Student: _____ Date of Birth: _____
Address: _____ Phone: _____
Name of Center: Pasdadena Christian Preschool License #: 1920004344

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.

Name of Medication	Form of Medication	Purpose / Medical Condition	Instructions (Dosage/Time)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize child care personnel to assist in the administration of medications described above to the child from _____(beginning date) to _____ (ending date).

SIGNATURE OF PARENT OR GUARDIAN (MANDATORY): _____

TO THE PHYSICIAN: Please complete and sign this form

1. If medication prescribed for a child must be given during school hours to prevent serious physical or behavioral problems: or
2. If over-the-counter medicines, lotions, creams, etc. are requested by the parents to administer to their child during school hours. It is a request and guide to authorized school personnel to assist the pupil with medication. Please check all that apply.

SIGNATURE OF PHYSICIAN: _____ DATE: _____ (REQUIRED!)

PHYSICIAN'S STAMP (OR PRINTED NAME, ADDRESS, & PHONE NUMBER):

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

Upon Completion, return medicine with a MEDICATION RETURN FORM AND A COPY OF THIS FORM to parent; and place original form in child's record.

STAFF: _____ DATE: _____

Date: _____

Parent Consent for Administration of NON-PRESCRIPTION Medication

Name of Student: _____ Date of Birth: _____
Address: _____ Phone: _____
Name of Center: Pasdadena Christian Preschool License #: 1920004344

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.

Name of Medication	Form of Medication	Purpose / Medical Condition	Instructions (Dosage/Time)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize child care personnel to assist in the administration of medications described above to the child from _____(beginning date) to _____ (ending date).

SIGNATURE OF PARENT OR GUARDIAN (MANDATORY): _____

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

Upon Completion, return medicine with a MEDICATION RETURN FORM AND A COPY OF THIS FORM to parent; and place original form in child's record.

STAFF: _____ DATE: _____

Allergy Action Plan

Name of Child: _____ Birthdate: _____ Room # : _____

It is our policy that each child has an Allergy Action Plan on file, regardless of severity. If your child has a life-threatening allergy, required medication and a signed Administration of Medication form must be on file in order to attend. 911 will automatically be called if an epi-pen is administered. **Please list allergens in order of severity from greatest concern to least concern. Write only one per section.**

ALLERGEN/INTOLERANCE (one per section): _____

☐ **ALLERGY (IgE)** ☐ **INTOLERANCE** ☐ **AVERSION** (Religious/Choice)

Symptoms are known to be: ☐Mild ☐Moderate ☐Severe (meds required) ☐**Life Threatening (Epi-Pen/911)**

KNOWN AFFECTED AREA(S): ☐ **Mouth** ☐ **Skin** ☐ **Gut** ☐ **Throat** ☐ **Lungs** ☐ **Heart**

EXPLANATION OF KNOWN SYMPTOMS: _____

ACTION PLAN: ☐Monitor ☐Call Parents ☐Medication _____ ☐ **Epi-Pen and Call 911**

Asthmatic? ☐**YES (Higher risk for severe reaction)** ☐**NO**

ALLERGEN/INTOLERANCE (one per section): _____

☐ **ALLERGY (IgE)** ☐ **INTOLERANCE** ☐ **AVERSION** (Religious/Choice)

Symptoms are known to be: ☐Mild ☐Moderate ☐Severe (meds required) ☐**Life Threatening (Epi-Pen/911)**

KNOWN AFFECTED AREA(S): ☐ **Mouth** ☐ **Skin** ☐ **Gut** ☐ **Throat** ☐ **Lungs** ☐ **Heart**

EXPLANATION OF KNOWN SYMPTOMS: _____

ACTION PLAN: ☐Monitor ☐Call Parents ☐Medication _____ ☐ **Epi-Pen and Call 911**

Asthmatic? ☐**YES (Higher risk for severe reaction)** ☐**NO**

ALLERGEN/INTOLERANCE (one per section): _____

☐ **ALLERGY (IgE)** ☐ **INTOLERANCE** ☐ **AVERSION** (Religious/Choice)

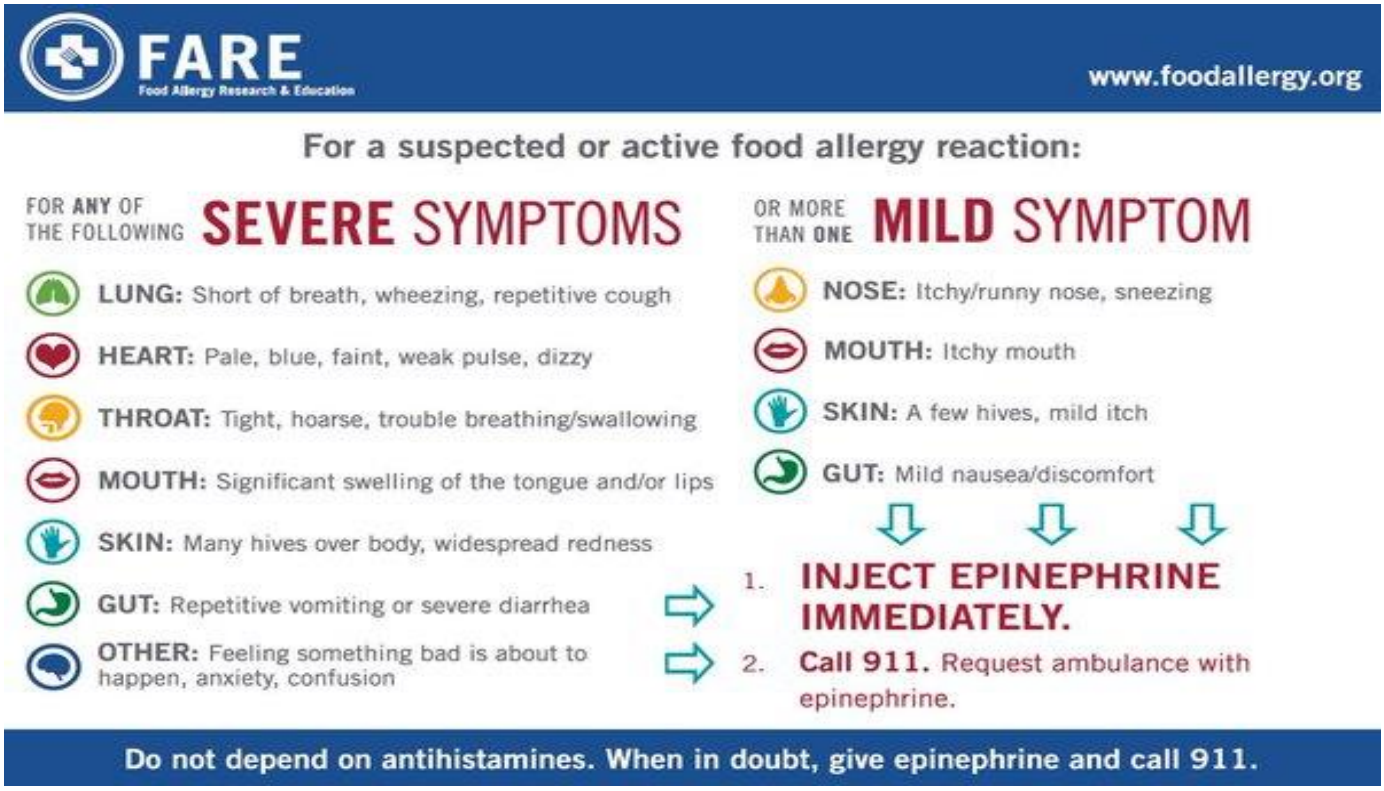
Symptoms are known to be: ☐Mild ☐Moderate ☐Severe (meds required) ☐**Life Threatening (Epi-Pen/911)**

KNOWN AFFECTED AREA(S): ☐ **Mouth** ☐ **Skin** ☐ **Gut** ☐ **Throat** ☐ **Lungs** ☐ **Heart**

EXPLANATION OF KNOWN SYMPTOMS: _____

ACTION PLAN: ☐Monitor ☐Call Parents ☐Medication _____ ☐ **Epi-Pen and Call 911**

Asthmatic? ☐**YES (Higher risk for severe reaction)** ☐**NO**



EMERGENCY CALLS

In Case of a Life-Threatening Emergency, Call 9-1-1 FIRST!
Our address is 1485 N. Los Robles Avenue, Pasadena, CA

	Name	Relationship	Phone Number
1			
2			
3			

Name of Doctor	Name of Practice	Phone Number

☐ **EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, I AUTHORIZE THE STAFF AT PCS TO MEDICATE AND/OR CALL 911!**

Parent/Guardian Signature: _____ Date: _____

PASADENA
CHRISTIAN
PRESCHOOL

Parent Handbook Signature Page

I/we _____and _____

parent(s) of _____ acknowledge I/we have received and will read the policies set forth by Pasadena Christian Preschool in the Preschool Parent Handbook.

I/we also acknowledge that by enrolling my/our child(ren) in Pasadena Christian Preschool, I/we agree to follow the Preschool policies as well as any local, state or federal regulations set forth by law.

Signed_____ Date:_____

Signed_____ Date:_____

EMERGENCY KITS

While we always pray that we will not experience a major emergency or disaster, it is prudent to be prepared in all situations.

Each student is required to provide a personal emergency bag. **The items for the kit should be placed in an 11" zip lock freezer bag.** It will be kept in in the PCS storage room, along with emergency food, water and supplies provided by the school.

****Please bring this kit on the FIRST day of school. Thanks!****

EMERGENCY KIT CONTENTS:

- ❒ A complete change of clothing
- ❒ One travel pack of wipes
- ❒ 3 granola bars – NO NUTS/NO PEANUTS
- ❒ 3 fruit rolls
- ❒ **1 pop-top** can of meat (chicken, tuna)
- ❒ **If your child wears diapers, please send 12 diapers in a separate ziplock labeled with his/her name and room number*.
- ❒ Optional: A letter from Mom and Dad that would comfort or reassure your child and a picture of the entire family if possible.

Please label your child's kit as follows:

2022-2023 ER Kit, Johnny Smith, PS Rm #

1485 N. Los Robles Ave., Pasadena, CA 91104 * 626.791.1277 * Fax – 626.398.9815