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**Parca REACH**
**After School Program Application**

Please check the appropriate information below.

**Hours**

_____7:00 AM to 8:30 AM (school days only)

_____11:40 AM to 6:00 PM

_____Arrival <u>before</u> 2:30 PM to 6:00 PM

_____Arrival <u>after</u> 2:30 PM to 6:00 PM

Enrollment Days

_____Monday _____Tuesday _____Wednesday _____Thursday _____Friday

Fee Information

_____Full Fee ____Department of Education Subsidy _____Other

**********

Child's Name: _____

Sex: M or F Birth Date: __/__/__ Ratio at School: __/__
(teacher to child)

Parents/ Guardians: _____

Address: _____

City/ State/ Zip: _____

Home Phone: _____ Work Phone: _____

School: _____ Room Number: _____ Teacher: _____

School Phone #: _____

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**ACKNOWLEDGEMENT**

I, the undersigned, verify that the information on this application is to the best of my knowledge, accurate and complete. I understand that any in accuracies will result in my child being enrolled for inaccurate sessions and times. I understand that admission to the Parca Project REACH program is contingent upon the fact that my child, named on this application, is not physically aggressive of abusive, nor requires any type of skilled nursing care, and can safely function in the staff to child ratio of the program. I understand failure to provide true and accurate information regarding my child will result in my child being immediately terminated from the Parca Project REACH program.

Parent(s)/ Guardian(s): _____ Date: __/__/__

Please fill out this application and any other enclosed paperwork. If your child has not attended program in the past you must then contact Cecilia O. Hinkston at (650) 871-8402 and make an appointment for an Intake Interview. Enrollment is completed on a first come, first serve basis.

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# REACH Program Admission Agreement

Parca REACH provides recreational opportunities in after-school, vacation, and summer care for children with and without disabilities. Although located on school grounds, Parca REACH is a separate organization from the school. REACH is a program of Parca, a private not-for-profit agency serving people with developmental disabilities and their families.

Fees are charged to assist in the costs of operating the program, while other grants and donations are obtained to subsidize the remaining operation cost. Special donations and grants are secured for the purchase of special equipment and for recreational and educational activities. To maintain "enrollment status" parents are required to abide by all program policies and procedures, including those on the Billing agreement.

Prior to admission into Parca REACH Program, parents/guardians must complete the following:

- Complete the Intake Process
- Be accepted into the program
- Complete and submit all enrollment paperwork
- Submit payment to Parca's accounting department
- Arrange transportation to and from the program

I/We understand that if I/we wish for my/our child to attend the Parca REACH Program on day(s) other than day(s) he/she has been enrolled, then I/we must call one day in advance to verify if space is available. I/we understand that Drop-in space is not guaranteed, therefore, my/our child cannot attend program without authorization from the Program Director or Program Manager. I/we also understand that my/our child cannot attend program before his/her designated time without prior approval from the Program Director or Program Manager.

This acknowledges that I/we have read the above agreement and agree to abide by the conditions. Also, I/we verify that I have received a copy of the Parca REACH Program Parent Handbook and Billing Agreement and have signed the receipt agreeing to abide by all the policies and procedures. I recognize the right of Community Care Licensing to review my child's records and interview my child at any time.

Parent/Guardian Signature Date

Parca REACH Representative Date

Revised 09/14/16

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Form Color: White

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# Medical and Emergency Information Form
# REACH Program

Child's Name:_____ Age:_____ Birthdate: _____

Address: _____ City: _____ Zip:_____

School Attending: _____ City: _____ Teacher: _____

Identifying Information: Sex _____ Weight _____ Height _____

Hair Color_____ Eye Color_____

**Adults Living With Client:**

| Name: | Relationship: | Work Phone: |
|---|---|---|
| Name: | Relationship: | Work Phone: |

Home Phone Number: _____

**Emergency Contacts and Persons Authorized to Pick up Client:** In the case of an emergency, we will always try to contact the parent first. In the event a parent cannot be reached, we need to contact at least two other friends/relatives. No adults other than those listed below will be able to pick up your child from our program unless we receive advance written notice from you.

| Name: | Relationship: | Work Phone:<br>Home Phone: |
|---|---|---|
| Name: | Relationship: | Work Phone:<br>Home Phone: |
| Name: | Relationship: | Work Phone:<br>Home Phone: |

**Physician or Dentist to be called in an Emergency:**

Physician Name:_____ Address: _____

Phone Number: _____ Medical Plan & Number: _____

Dentist Name:_____ Address: _____

Phone Number: _____ Dental Plan & Number: _____



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**Medical History**

| | Date mm/dd/yy | | Date mm/dd/yy |
|---|---|---|---|
| ___ Appendicitis | _____ | ___ Diabetes | _____ |
| ___ Tonsillectomy | _____ | ___ Epilepsy | _____ |
| ___ Mumps | _____ | ___ Rheumatic Fever | _____ |
| ___ Measles | _____ | ___ Asthma | _____ |
| ___ Other Operation(s)_____ | | ___ Chicken Pox | _____ |

(Please explain) _____

**Allergies (Please check all that apply and explain when needed)**

___ Penicillin ___ Animals:_____

___ Bee Stings ___ Food: _____

___ Hayfever ___ Other: _____

**Medications**

Type: _____ Dosage: _____

Type: _____ Dosage: _____

Type: _____ Dosage: _____

Type: _____ Dosage: _____

**Please note: If you need your child's medication administered at Project REACH, please fill out a Medication Release Form.**

**Photo Release**

I hereby _____ give permission _____do not give permission to Project REACH to photograph my child, _____ _____ , for media use (including but not limited to television, magazine, newspaper, lectures, etc.); without limitation to use any pictures, film, and/or stories in connection with any of the work of said Project REACH; without compensation of any kind. I hereby hold harmless Project REACH from any claims whatsoever which may arise.

_____

Parent/Guardian Signature Date

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**Consent for Medical Treatment**

As the parent, agency representative, or legal guardian, I hereby give consent to PARCA/Project REACH to provide all emergency dental or medical care prescribed by a duly licensed physician (MD) or dentist (DDS) for

_____.

(Child's Name)

This care may be given under whatever conditions are necessary to preserve the life, limb, ore well being of my dependent.

**Child has the Following Medication Allergies:**

_____

_____

_____

_____

Parent/Guardian Signature Date

Note: please provide a current picture of your child

**Photograph**

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**Individual receiving REACH services on which information is being collected:**

Child's Name

Birth Date Approximate Date of Services

**Agency and/or individual service to be contacted:**

Name of Agency or Individual

Address

Phone Number

**School Program**

During the school year, the REACH Program Coordinator conducts teacher conferences and/or school visits to all the children attending REACH.

I_____, give my consent for the above agency and/or individual to be contacted by a Parca REACH employee, in regards to my child's development and growth. I understand the information will be used to further enhance my child's growth and success in the REACH Program.

Parent Signature Date

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# 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 |
|---|---|---|---|---|---|
| ☐ 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 | | |
|---|---|---|
| Department of Social Services | | |
| ADDRESS | | |
| Community Care Licensing | | |
| 851 Traeger Ave., Suite 360 | | |
| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
| San Bruno, CA | 94066 | 650-266-8800 |

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) |
|---|---|
| Parca REACH Program | 130 Cambridge Ln., San Bruno, CA 94066 |

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

# CHILD CARE CENTER
# NOTIFICATION OF PARENTS' RIGHTS

## PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 851 Traeger Ave., Suite 360, San Bruno, CA 94066

   Licensing Office Telephone #: 650-266-8800

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.

Parca REACH Program
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***

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# Statistical Form

In order to keep the fees for Children's Services at affordable levels, Parca receives support from many private foundations and various city and state grants.

In order to receive these funds, Parca is required to provide information on a regular basis to these entities. The following information will be used for statistical purposes only, and you name/name of participating family member will be kept confidential. Thank you for your compliance.

**Name: _____**

**City of Residence:_____**

**Head of Household Information (please check one):**

**_____Male** **_____Elderly (over age 62)**
**_____Female** **_____Disabled Head of Household**

**Ethnicity Information:**

*If you are Not Hispanic/Latino please check one of the following:*

_____American Indian/Alaska Native
_____American Indian/Alaska Native and Black/African American
_____American Indian/Alaska Native and White
_____Asian
_____Asian and White
_____Black/African American
_____Black/African and White
_____Native Hawaiian/Other Pacific Islander
_____White
_____Other

*If you ARE Hispanic/Latino, please check one of the following:*

_____Hispanic/Latino American Indian/Alaska Native
_____Hispanic/Latino American Indian/Alaska Native and Black/African American
_____Hispanic/Latino American Indian/Alaska Native and White
_____Hispanic/Latino Asian
_____Hispanic/Latino Asian and White
_____Hispanic/Latino Black/African American
_____Hispanic/Latino Black/African American and White
_____Hispanic/Latino Native Hawaiian/Other Pacific Islander
_____Hispanic/Latino White
_____Hispanic/Latino Other

Income Data:
Number of people in your household:_____
Your annual combined household income: $_____

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**Parca REACH Program Medication Permission Slip**

I, _____, give permission for the Parca REACH staff to administer to my child ,_____, the medication indicated below in the designated amount at the designated time.

1. Medication Name:_____
(please include the medication's generic name)
Dosage:_____

Time Given:_____

2. Medication Name:_____
(please indicate medication's generic name)
Dosage:_____

Time Given:_____

3. Medication Name:_____
(please include medication's generic name)
Dosage:_____

Time Given:_____

I understand that the REACH staff can only administer medication if it is in it's original bottle, a Medication Permission Slip is on file, and if the information on the permission slip matches the prescription on the bottle.

Parent Signature:_____ Date:_____

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Form Color: White

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# Cultural Background Survey

Parca's REACH Program strives to teach children the acceptance and tolerance of differences and expose them to new ideas and cultures. This survey was developed so that the program can appropriately reflect and celebrate each child's diverse background.

Participant's Ethnicity: _____

Languages the Participant understands: _____

Can the Participant speak the above languages:_____ Fluently _____Somewhat

Does the Participant know Sign Language? _____Yes _____No

Participant's country of birth: _____

Holidays the Participant celebrates: _____

Holidays the Participant does not celebrate: _____

Family Traditions: _____

_____

_____

_____

Suggestions to enable staff to better serve your child while respecting his/her diverse background and, at the same time, provide anti-biased curriculum: _____

_____

_____

_____

_____

_____

Thank you. Your input is valuable to the quality of the program!