REACH (Recreational Experiences for all Children) offers a full inclusion after school program for children with and without developmental disabilities. It provides an atmosphere where children can make new friends, have fun, and grow as individuals.

DATES: August 2019-June 2020

HOURS OF OPERATION & COST
Monday through Friday

Early morning care (7:00am to 8:15am).................................$111/month
Kindergarten only (12 to 6:00pm).......................................$525/month
Part time Kinder (12-2:30 Monday, Tuesday, Wednesday & Friday; 12-1:15pm Thursday).................................$200/month
Arrival (before 2:40 to 6:00pm)............................................$504/month
Arrival (after 2:40pm to 6:00pm)...........................................$389/month
School days (8am to 6pm) for school year children.................$30/day

Sibling Discount 10% off monthly fee and drop in rates

INTAKE PROCEDURE
All potential intakes must participate in the Intake Assessment Process to assess whether or not the child meets the entrance criteria for the program. To begin the Intake Process families must participate in an initial Intake Interview with the Program Manager. To schedule an appointment please call the REACH program (650) 871-8402 or send an e-mail, crestmoor@parca.org.

ENROLLMENT DEADLINE
Spaces are based on a first come, first serve basis.

Enroll your child today! Call (650)871-8402 or email crestmoor@parca.org. Find out more at www.parca.org
Parca REACH
After School Program Application

Please check the appropriate information below.

**Hours**
- _____ 7:00 AM to 8:30 AM (school days only)
- _____ 12 PM to 6:00 PM
- _____ Arrival before 2:30 PM to 6:00 PM
- _____ Arrival after 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 #: ______________________
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 inaccuracies 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.
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

Distribution: Child's file
Form Color: White
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:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Phone:</td>
</tr>
</tbody>
</table>

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: ____________________________
## Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date mm/dd/yy</th>
<th>Date mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendicitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Operation(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please explain) ________________________________________________________________

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

- ___ Penicillin
- ___ Animals:
- ___ Bee Stings
- ___ Food:
- ___ Hayfever
- ___ Other:

### Medications

<table>
<thead>
<tr>
<th>Type</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Child’s Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Approximate Date of Services</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Name of Agency or Individual</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Parent Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
# Child's Preadmission Health History—Parent's Report

**Child's Name**: 

**Sex**: 

**Birth Date**: 

**Father/Father's Domestic Partner's Name**: 

**Does Father/Father's Domestic Partner Live in Home with Child?**: 

**Mother/Mother's Domestic Partner's Name**: 

**Does Mother/Mother's Domestic Partner Live in Home with Child?**: 

**Has Child Seen 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**: 

## Past Illnesses

- **Check Illnesses that child has had and specify approximate dates of illnesses:**
  
  - Chicken Pox
  - Asthma
  - Rheumatic Fever
  - Hay Fever
  - Diabetes
  - Epilepsy
  - Whooping Cough
  - Mumps
  - Poliomyelitis
  - Ten-Day Measles (Rubella)
  - Three-Day Measles (Rubella)

## 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?**

**Diet Pattern**: (What does child usually eat for these meals?)

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
</tr>
</thead>
</table>

## Any Food Dislikes?  

## Any Eating Problems?

## Is Child Toilet Trained?*

**If Yes, at What Stage?**

**Are Bowel Movements Regular?**

**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?*

**If Yes, Name of Doctor**: 

**Does Child Take Prescribed Medication(s)?**

**If Yes, What Kind and Any Side Effects**: 

**Does Child Use Any Special Device(s)?**

**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**

---

* LIC 702 (04) (Confidential)
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:

Department of Social Services

NAME
Community Care Licensing

ADDRESS
851 Traeger Ave., Suite 360

CITY: San Bruno, CA
ZIP CODE: 94066
AREA CODE/TELEPHONE NUMBER: 650-266-8800

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) Parca REACH Program
(ADDRESS OF THE FACILITY) 130 Cambridge Ln., San Bruno, CA 94066

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

LIC 613A (6/09)
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

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
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 your 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  
_____ Female  

_____ Elderly (over age 62)  
_____ 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: $________
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 its 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: ________________

Distribution: Child’s file
Form Color: White
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!