KINDERLAND CHILD DEVELOPMENT CENTER
1630 VICTOR AVENUE
REDDING, CA 96003

REGISTRATION PAYMENT AGREEMENT
September 201__-August 202__

I understand that a registration fee of $50.00 is due for my child/ren
________________________. I wish to pay this in

___ Full

___ 2 payments

Registration fees must be paid in full 1 month from first date of attendance.

___________________________
Parent
KINDERLAND CONTRACT

The Kinderland Child Development Center parent handbook is available on-line. Written copies are available on request. Additional children enrolled in the future by this family will be covered under this contract as well. Kinderland reserves the right to change policies at any time. You will be notified of changes and copies of amended pages will be posted on the website. Again, written copies will be available on request.

I have read and understand the handbook. By signing this contract, I agree to abide by Kinderland’s policies, rules and regulations.

CHILD(REN)’S NAME

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

PRINTED NAME

SOCIAL SECURITY # DRIVER LICENSE # DATE OF BIRTH

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

PRINTED NAME

SOCIAL SECURITY # DRIVER LICENSE # DATE OF BIRTH

Social Security and Driver's License numbers are required if paying by check. If we do not have these on file, you will need to pay by cash or credit card only. No checks will be accepted.

AUTHORIZED KINDERLAND REPRESENTATIVE DATE
SCHEDULE OF SERVICES

Child(ren): ______________________________________

Print Name

Please complete and return to director. Indicate below which child care services you need.

Full day - Mon. Tues. Wed. Thurs. Fri.
Drop- Off - Schedule will vary, Call in Advance

SCHOOL -AGE CHILDREN – Kindergarten and Up
Before School
After School
Holidays & Summer Only

__________________________________________  ______________
Parent Signature                           Date
## IDENTIFICATION AND EMERGENCY INFORMATION

**CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**

To Be Completed by Parent or Authorized Representative

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST</th>
<th>MIDDLE</th>
<th>FIRST</th>
<th>SEX</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>FATHER/GUARDIAN/FATHER'S DOMESTIC PARTNER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
<td></td>
</tr>
<tr>
<td>HOME ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>MOTHER/GUARDIAN/MOTHER'S DOMESTIC PARTNER'S NAME</td>
<td>LAST</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>BUSINESS TELEPHONE</td>
<td></td>
</tr>
<tr>
<td>HOME ADDRESS</td>
<td>NUMBER</td>
<td>STREET</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>PERSON RESPONSIBLE FOR CHILD</td>
<td>LAST NAME</td>
<td>MIDDLE</td>
<td>FIRST</td>
<td>HOME TELEPHONE</td>
<td>BUSINESS TELEPHONE</td>
</tr>
</tbody>
</table>

### ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
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</tbody>
</table>

### PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>ADDRESS</th>
<th>MEDICAL PLAN AND NUMBER</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTIST</td>
<td>ADDRESS</td>
<td>MEDICAL PLAN AND NUMBER</td>
<td>TELEPHONE</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

### 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: [Insert Name]

**Sex:** [ ] Male  [ ] Female  
**Birth Date:** [ ]

**Father/Mother's Domestic Partner's Name:** [Insert Name]

**Does Father/Mother's Domestic Partner Live in Home with Child?** [ ] Yes  [ ] No

**Mother/Father's Domestic Partner's Name:** [Insert Name]

**Does Mother/Father's Domestic Partner Live in Home with Child?** [ ] Yes  [ ] No

**Is Child Under Regular Supervision of Physician?** [ ] Yes  [ ] No

**Date of Last Physical/Medical Examination:** [ ]

### Developmental History
(Children 1-2 years and preschool-age children only)

<table>
<thead>
<tr>
<th>Task at*</th>
<th>Months</th>
<th>Began Talking at*</th>
<th>Months</th>
<th>Toilet Training Started at*</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Walk</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 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)

**Specify Any Other Serious or Severe Illnesses or Accidents:**

**Does Child Have Frequent Cold?** [ ] Yes  [ ] No  
**How Many in Last Year?** [ ]

### 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?** [ ]

**Breakfast:** [ ]

**Lunch:** [ ]

**Dinner:** [ ]

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

**What Are Usual Eating Hours?**
- Breakfast: [ ]
- Lunch: [ ]
- Dinner: [ ]

### Any Food Dislikes?

**Are Bowel Movements Regular?** [ ] Yes  [ ] No  
**What Is Usual Time?** [ ]

### Eating Problems?

**Is Child Toilet Trained?** [ ] Yes  [ ] No  
**If Yes, At What Stage?** [ ]

**Are Bowel Movements Regular?** [ ] Yes  [ ] No  
**What Is Usual Time?** [ ]

### Parent's Evaluation of Child's Health

**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/Special Needs? (Explain)**

**What Is the Plan for Care When the Child Is Ill?**

**Reason for Requesting Day Care Placement**

**Parent's Signature:** [Insert Signature]

**Date:** [ ]

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**LC 702 (6/88) (CONFIDENTIAL)**
Immunization Records are required prior to start date.
Thank You
PART A – PARENT’S CONSENT (TO BE COMPLETED BY PARENT)

(NAME OF CHILD) ______, born ______ (BIRTH DATE) ______ is being studied for readiness to enter ______. This Child Care Center/School provides a program which extends from ______:______ 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.)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLIO (OPV OR IPV)</td>
<td>/</td>
<td>/</td>
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<td>/</td>
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</tr>
<tr>
<td>DTP/DTaP/DTd (IF PERTUSSIS AND DIPHTHERIA ARE INCLUDED)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>(REQUIRES FOR CHILD CARE ONLY)</td>
<td>/</td>
<td>/</td>
<td>/</td>
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<td>/</td>
</tr>
<tr>
<td>MMR (MEASLES, Mumps, AND RUBELLA)</td>
<td>/</td>
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</tr>
<tr>
<td>VARICELLA (CHICKENPOX)</td>
<td>/</td>
<td>/</td>
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</tr>
</tbody>
</table>

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
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: 520 Cohasset Rd #6 Chico 95926
   Licensing Office Telephone #: (530) 859-5033

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.

________________________________________
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
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

520 Cohasset Rd # 6

CITY

Chico, Ca

ZIP CODE

95926

AREA CODE/TELEPHONE NUMBER

530-895-5033

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 NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

LIC 613A (8/98)
MEDIA PERMISSION

Child(ren): ________________________________

I give permission for pictures/video of my child(ren) to be used or posted with the following:

Please Check All That Apply

___ Web Site – kinderlandusa.com

___ Facebook – kinderlandusa@facebook.com

___ Newspaper (rare)

___ Television (rare)

___ Classroom/Center

___ First Name(s) may be used

I understand that last names will not be used unless specific permission is granted.

______________________________  _______________________
Parent Signature                  Date
**MEAL BENEFIT FORM FOR CHILDREN**

**PROGRAM YEAR _______________**

Name of Child Care Center: ________________________________________________

Please read the instructions. If you need help completing this form, call: ____________________________

Complete, sign, and return form to: ____________________________________________

1. **CHILD INFORMATION**

List names of all children enrolled for care.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Foster Child?**</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

*If all children listed are foster children, go to Section 4.

2. **BENEFITS**

If you are receiving CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and do not complete Section 3. Go to Section 4.

<table>
<thead>
<tr>
<th>Program</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalFresh</td>
<td></td>
</tr>
<tr>
<td>CalWORKs</td>
<td></td>
</tr>
<tr>
<td>FDPIR</td>
<td></td>
</tr>
</tbody>
</table>

3. **ALL OTHER HOUSEHOLDS**

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. __________________________ Go to Section 4.

Applicants without income are requested to write a zero in the applicable field or mark no income. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. **LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE**

**PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct and that the CalFresh, CalWORKs, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the meal benefit form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

**Printed Name:** __________________________

**Last Four Digits of SSN:** __________________________

**No SSN:** __________________________

**Signature of Parent or Guardian:** __________________________

**Date:** __________________________

**PRIVACY ACT STATEMENT**

The Richard B. Russell National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKs), Program or FDPIR case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.
The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

Please mark one of the following ethnic identities:

Hispanic or Latino
Not Hispanic or Latino

FOR AGENCY USE ONLY

CATEGORICAL ELIGIBILITY

CalFresh/CalWORKs/FDPIR household categorically eligible? Yes ___ No ___
Foster child automatically eligible free? Yes ___ No ___

INCOME ELIGIBILITY

Annual Conversion (required if household reports various pay frequencies in Section 3):
weekly times (x) 52, every 2 weeks x 26, twice a month x 24, monthly x 12
Total Household Income and Frequency: $________ per _______
Household Size: ______

ELIGIBILITY CLASSIFICATION

Eligibility Classification: Free ___ Reduced-price ___ Base ___
Determining Official Name: __________________________ Date: __________
Determining Official Signature: __________________________
DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American—A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino