

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		
LOS ANGELES CHILD CARE EAST		
ADDRESS		
1000 Corporate CTR Dr, STE 200B		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterey Park	91754	1-323-981-3382

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)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

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

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

_____ 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

()

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
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

Dental: _____

Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)					
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

- ☐ Risk factors not present; TB skin test not required.
- ☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
_____ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
 - * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
 - * Live in out-of-home placements.
 - * Have, or are suspected to have, HIV infection.
 - * Live with an adult with HIV seropositivity.
 - * Live with an adult who has been incarcerated in the last five years.
 - * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
 - * Have abnormalities on chest X-ray suggestive of TB.
 - * Have clinical evidence of TB.
-

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

GASTROSTOMY - TUBE CARE: PHYSICIAN'S CHECKLIST (CHILD CARE FACILITIES)
(CHILD'S EVALUATION FOR APPROPRIATENESS OF CARE)**PART A - AUTHORIZED REPRESENTATIVE'S CONSENT**_____, born _____, is being considered to receive **gastrostomy-tube**
(NAME OF CHILD) (BIRTH DATE)(G-tube) feeding and/or liquid medication through a G-tube at _____
(NAME OF CHILD CARE FACILITY)

The child would attend this program from _____ a.m./p.m. to _____ a.m./p.m. _____ days a week.

Please provide the information required below on the above-named child. I hereby authorize release of medical information contained in this report to the above-named child care facility (center/school/family child care home).

(SIGNATURE OF CHILD'S AUTHORIZED REPRESENTATIVE)_____
(DATE)**PART B - INFORMATION TO BE COMPLETED BY PHYSICIAN****Assessment of Stability of Child's Medical Condition**Is the child's medical condition stable enough for a layperson with instruction/training to safely administer G-tube feeding, and liquid medication through a G-tube (if applicable), to the child in a child care setting? ☐ Yes ☐ No

Please explain: _____

Designation of Person to Provide Instruction on G-Tube Care

If the answer to the above question is yes, each person who administers G-tube care to the child must be instructed on how to provide that care by a competent person designated by the child's physician. Please indicate the person you designate to provide this instruction with regard to the above-named child (may be the child's authorized representative):

Name _____ Phone Number(s): _____

Address _____

Title or Relationship to Child: _____

Medical Assessment (same information as on the LIC 701 for centers)

A medical assessment is required for all children who receive G-tube care at a child care facility (including a family child care home). Please complete the following information for the above-named child. (A completed LIC 701, "Physician's Report - Child Care Centers," may be attached for a child who attends a child care center.)

PROBLEMS OF WHICH YOU SHOULD BE AWARE:

HEARING:	ALLERGIES:	MEDICINE:
VISION:	INSECT STINGS:	
DEVELOPMENTAL:	Food:	
LANGUAGE/SPEECH:	ASTHMA:	
	OTHER:	

OTHER (INCLUDE BEHAVIORAL CONCERNS):

COMMENTS/EXPLANATIONS:

MEDICATIONS PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

PHYSICIAN'S WRITTEN INSTRUCTIONS

Please provide specific steps for a layperson to administer food or liquid medication through a G-tube to the child and provide related necessary care. The instructions must be updated annually, or whenever the child's needs dictate (for example, if the child obtains a different type of G-tube or if the frequency of feeding and amount/type of formula or liquid medication to be administered to the child changes). Please attach an extra sheet(s) with the instructions. The instructions must include, but may not be limited to, the following:

- 1) Any limitation or modifications to normal activity required by the presence of the G-tube.
- 2) Frequency of feeding and amount/type of formula or liquid medication to be administered to the child in accordance with the physician's prescription.
- 3) Hydration of the child with water or other liquids as determined by the child's physician.
- 4) Method of feeding, administering liquid medication or hydrating the child, including how high the syringe is to be held during the feeding. If applicable, this includes how to use an enteral (means "into the stomach") feeding pump.
- 5) Positioning of the child.
- 6) Potential side effects, e.g., nausea, vomiting, abdominal cramping. (Decompression—the removal of gas in the gastrointestinal tract—is not to be performed on the child beyond briefly removing the cap from the gastric feeding button, which may or may not help relieve the child's discomfort.)
- 7) Specific actions to be taken in the event of specific side effects or an inability to complete a feeding, administration of liquid medication to the child, or hydration of the child in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- 8) How and when to flush out the G-tube with water, including what to do if the G-tube becomes clogged. Specific instructions on how many cc's of water to use when flushing out the G-tube.
- 9) Instructions for proper sanitation, including care and cleaning of the stoma site.
- 10) Instructions for proper storage of the formula or the liquid medication.
- 11) Instructions of proper care and storage of equipment.
- 12) The telephone number and address of the child's physician or designee (below).

PHYSICIAN:	DATE OF PHYSICAL EXAM:	CURRENT DATE:
ADDRESS:		TELEPHONE:
SIGNATURE:		
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> PHYSICIAN</div><div><input type="checkbox"/> PHYSICIAN'S ASSISTANT</div><div><input type="checkbox"/> NURSE PRACTITIONER</div></div>		

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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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	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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
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**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: LOS ANGELES CHILD CARE EAST

Licensing Office Address: 1000 Corporate CTR Dr, STE 200B, Monterey Park 91754

Licensing Office Telephone #: 1-323-981-3382

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.

The YMCA of West San Gabriel Valley

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

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is <http://ccld.ca.gov/contact.htm>.

**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ Sex: M ☐ F ☐ Birthdate _____ Place of Birth _____

Name of Parent or Guardian _____ Race/Ethnicity: ☐ White, not Hispanic ☐ Hispanic ☐ Black ☐ Other: _____ Address _____

Telephone _____ City _____ ZIP _____
Daytime _____ Nighttime _____

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV or IPV)					Booster
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)					
MMR (Measles, mumps, and rubella)					
HIB (Required only for child care and preschool)					
HEPATITIS B					
VARICELLA (Chickenpox)					
HEPATITIS A (Not required)					

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date _____
Staff _____
Signature _____

Record Presented was:

- ☐ Yellow California Immunization Record
☐ Out-of-state school record
☐ Other immunization record

Specify: _____

II. STATUS OF REQUIREMENTS

☐ A. All Requirements are met.

Date _____ / _____ / _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:

- ☐ C. Medical Reasons—Permanent
☐ D. Medical Reasons—Temporary
☐ E. Personal Beliefs

III. 7th GRADE ENTRY

☐ A. All Requirements are met.

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Name _____ Date _____

Name _____ Date _____

TB SKIN TESTS	Type* <input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other	Date given	Date read	mm indur	Impression <input type="checkbox"/> Pos <input type="checkbox"/> Neg	CHEST X-RAY (Necessary if skin test positive)
						Film date: _____ Impression: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
						Person is free of communicable tuberculosis: <input type="checkbox"/> yes <input type="checkbox"/> no

*If required for school entry, must be Mantoux unless exception granted by local health department.

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K-12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
 - A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
 - B. If the child has met all immunization requirements, check box A and write in date.
 - C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
 - D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met; check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
 - E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN
Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la comunidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) _____ Date (Fecha) _____

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____ Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.