



# City of South Pasadena Camp Med Thanksgiving/Winter Break Day Care Program 2011

## Registration Admission Agreement (One application per each child please)

Thank you for your interest in the City of South Pasadena Camp Med Thanksgiving/Winter Break Day Care Programs. The hours of operation for our Thanksgiving and Winter Break programs are as follows:

	Monday	Tuesday	Wednesday	Thursday	Friday
Thanksgiving Week Hours (11/21/11 – 11/25/11)	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm	Closed	Closed
Winter Break (Week 1) Hours (12/19/11 – 12/23/11)	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm
Winter Break (Week 2) Hours (12/26/11 – 12/30/11)	Closed	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm	7:30am – 6:30pm

Weekly fees are **\$125 for Full-time (4 or 5 days)** and **\$92 for Part-time (1-3 days)**.

Our program offers an enjoyable and safe environment for all children. The program entails recreational activities ranging from: sports activities, arts and crafts, games, reading time and snacks. Two snacks are provided daily and each child will need to bring their own lunch. We are a state licensed facility with caring and experienced, CPR/First Aid certified staff.

Our address is: 815 Mission St., South Pasadena, CA 91030.  
If you wish to contact us by phone please call (626) 403-7380.

I understand that I am enrolling my child \_\_\_\_\_ in the  
Camp Med (please check):     Thanksgiving Program     Winter Break Program     Both

School \_\_\_\_\_ Grade \_\_\_\_\_

- I will be sending my child full-time (please circle)    YES    NO
- If part-time, I need care provided on the following days (please circle):    M    T    W    Th    F
  1. I understand that my payment is required before services rendered (i.e., payment must be received by the Friday before each week my child will attend.)
  2. I will update my child's file information as changes occur.
  3. I understand that the Camp Med staff will assume responsibility for my child from the time he/she is signed into camp until my child leaves the program according to instructions for departure.
  4. I understand that if a medical emergency arises, the Camp Med staff will first attempt to contact me. If I am unable to be reached, the staff will contact my child's doctor. In the event that immediate hospital attention is necessary, an ambulance or emergency vehicle may take my child to the hospital.
  5. Camp Med closes at 6:30pm M-F, unless otherwise noted above. I understand that after a ten-minute grace period after Camp Med closes, I will be charged a **\$1 per minute rate in addition to the regular fee**. I also understand that if my child remains at the facility at 7:00pm, a staff member may escort my child to the South Pasadena Police Station until he/she is picked up.

**South Pasadena Police Station    1422 Mission Street    Phone: (626) 403-7270**

I agree to adhere to the stated policies and procedures of the Camp Med Day Care Program, and give my child permission to participate in the program.

Your Name (printed) \_\_\_\_\_ Relation to child \_\_\_\_\_

Email address \_\_\_\_\_ Please provide your email address so we can keep you updated with the latest information

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IDENTIFICATION AND EMERGENCY INFORMATION**  
**CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**  
To Be Completed by Parent or Guardian

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
FATHER'S NAME	LAST	MIDDLE	FIRST	BIRTHDATE	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
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 GUARDIAN)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT OR GUARDIAN	DATE
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**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR**

DATE OF ADMISSION	DATE LEFT
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### 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**

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?

**PARENT'S EVALUATION OF CHILD'S HEALTH**

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> 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
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## Camp Med Liability Waiver and Consent Form

Participants Name(s): \_\_\_\_\_

1. I fully understand that the participation of my child/children in South Pasadena Camp Med Thanksgiving and/or Winter Break Program and related activities associated with the program (hereinafter “program”) exposes them to the risk of personal injury, death or property damage. I hereby acknowledge that I am granting my child/children permission to participate in the program and agree to assume any such risks.

2. In consideration for being permitted to participate in the program, I hereby agree, for myself, my heirs, administrators, executors and assigns, to indemnify and hold harmless the City, its officers, employees, or agents from any and all claims, demands, actions or suits arising out of or in connection with my child’s participation in the program from whatever cause, including the active or passive negligence of the City or any other participant in the activity.

3. I agree to instruct my child to cooperate to the fullest with the staff of the program(s) sponsored by the South Pasadena Community Services Department

4. I agree to represent that my child has no physical impairment with the activities planned. (See Health History form to inform us in writing of any medical problems.)

5. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital services that may be rendered to said child under general or special instructions of the emergency room physician, whether such diagnosis or treatment is rendered at the hospital.

6. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage said physician(s) to exercise his/her best judgment as to requirement of such diagnosis or treatment. This release and consent shall remain in effect until the end of the Camp Med Thanksgiving and/or Winter Break program.

I HAVE CAREFULLY READ THIS RELEASE, HOLD HARMLESS AND AGREEMENT NOT TO SUE AND FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT IT IS A FULL RELEASE OF ANY AND ALL POTENTIAL AND ACTUAL LIABILITY WITH THE CITY OF SOUTH PASADENA AND SIGN ON MY OWN FREE WILL.

Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_



## Camp Med Photo/Video Release Form

I hereby give permission for images of my child, captured during regular and special Camp Med activities through video, photo and digital camera, to be used solely for the purposes of promotional material and publications, and waive any rights of compensation or ownership thereto.

Name of Participant (please print): \_\_\_\_\_

Name of Parent/Guardian (please print): \_\_\_\_\_

Parent//Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Participants Code of Conduct

We would like you and every participant to have a great time. This means abiding by the rules of common courtesy and agreeing to the following:

1. I will treat participants and staff with respect and common courtesy.
2. If I have a complaint or concern about anything, or anyone, I will contact a staff member (in private if necessary) rather than be derogatory or negative in public.
3. I will refrain from any physical violence of any kind, or the threat of physical violence, towards a fellow participant, the public or representative of the City of South Pasadena Community Services Department.
4. I will refrain from any objectionable demonstrations, such as throwing items, or any other forceful actions towards fellow participants, representative of the City of South Pasadena Community Services Department.
5. I will refrain from any verbal abuse upon a participant or representative of the City of South Pasadena Community Services Department.
6. I will refrain from using profanity, obscene or vulgar language in any manner at any time.
7. I will stay in the specified Camp Med limits at all times unless a representative of the City of South Pasadena Community Services Department instructs me otherwise.

I agree to adhere to the Code of Conduct for Camp Med and cooperate with the rules and direction provided by the Community Services staff while enrolled in the program. I understand that if I violate these rules that I may no longer be able to participate in the Camp Med program.

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Participant's Name

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Participant's Signature

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Parent or Guardian's Signature

**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  
 Community Care Licensing Division  
 Los Angeles Child Care East  
 1000 Corporate Center Drive Suite 200-B  
 Monterey Park, CA 91754

AREA CODE/TELEPHONE NUMBER

(213) 981-3350

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

**PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(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: \_\_\_\_\_

Licensing Office Address: \_\_\_\_\_

Licensing Office Telephone #: \_\_\_\_\_

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.**

LIC 995 (ENG/SP) (8/02)

(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.

\_\_\_\_\_  
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.**

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