

PRESCHOOL APPLICATION

LSC16-1/22

Today's Date _____ School Year _____ Social Security # _____

Student's Name _____
Last (legal) First Middle

Age _____ Birth Date _____ Birthplace _____
City State

_____ **Copy of Certified Birth Certificate and Current Immunization Record are attached. (Immunizations must be up-to-date before the first day of school.)**

_____ **A Physician's Report must be completed BEFORE the child attends. (The physical is good for one year.)**

Please check the program desired.

Preschool (At least 3 yrs old and potty-trained)

_____ 5 Full Days (M-F 8:15 – 3:15)
_____ 5 Half Days (M-F 8:15 – 11:15)

Kindergarten Readiness (Must be 4 yrs old before September 1st)

_____ (M-F 8:30 – 11:30) _____ Add Afternoons (11:30 -3:30)

PARENTS/GUARDIANS INFORMATION – Who Student resides with:

Parent #1 Name _____ Relation to student _____

Home Phone # _____ Cell Phone # _____ E-Mail _____

Mailing Address _____

Occupation _____ Street _____ City _____ Zip _____
Employer _____ Phone _____

Employers Address _____

Church Affiliation _____ Street _____ City _____ Zip _____
Member? _____

Parent #2 Name _____ Relation to student _____

Home Phone # _____ Cell Phone # _____ E-Mail _____

Mailing Address _____

Occupation _____ Street _____ City _____ Zip _____
Employer _____ Phone _____

Employers Address _____

Church Affiliation _____ Street _____ City _____ Zip _____
Member? _____

STUDENT INFORMATION

Student's Church Affiliation _____ City _____

| | | | |
|--------------------|---------------|------------------|-------------|
| Church Attendance: | Regular _____ | Occasional _____ | Never _____ |
| Sunday School: | Regular _____ | Occasional _____ | Never _____ |
| Youth Group: | Regular _____ | Occasional _____ | Never _____ |

Please circle the areas that are of interest to your student:
art music academics social athletics

Has the student had problems in school with regard to:
____ social adjustment ____ discipline ____ academic ____ other (please explain)

Who referred you to our school? _____

Are you applying for the admission of all your children of school age? _____

If not, why? _____

Please state briefly the basic tenets of your personal religious convictions: _____

For the safety and best interest of the student, if there are legal agreements that involve taking the student to and from school or restrictions of visitation/custody, we must have these documents in the student's record.

No student will be refused admission on the basis of race. Liberty Christian School is committed to a policy of non-discrimination on the basis of ethnic origin or sex in its admissions policies, educational programs, activities, and employment.

A Certified Birth Certificate and current immunization record must accompany this application for student's entering Preschool.

All immunizations and current physician's report must be on file BEFORE the first day of school.

By signing below you are agreeing to the Statement of Cooperation found on the following page.

Parent Signature

Parent Signature

We understand the registration fee is non-refundable

Parent Initial

Parent Initial

LIBERTY CHRISTIAN SCHOOL REDDING

STATEMENT OF COOPERATION

FOR NEW PARENTS AND STUDENT ENROLLEES: Please read the entire Handbook for Parents and Students before signing the application forms. This will give opportunity for any questions to be answered by the administration before a misunderstanding arises. Please read especially the section on "Privilege of Attendance."

FOR RETURNING PARENTS AND STUDENT ENROLLEES: Please review your Handbook before signing the application form and signature line below.

FOR ALL PARENTS - PLEASE READ THE FOLLOWING: Upon acceptance of the student described on the attached application, we hereby agree to accept all rules and regulations of the school and authorize the school administration to exercise such disciplinary measures as may be deemed necessary and proper.

We will give active support to the school program in every way and strive to be regular in attendance at parent meetings and other school functions to which parents are invited.

We agree that our child may participate in all regular school functions including field trips away from the school premises, and we absolve the school from liability to us or our child because of any injury which may occur to our child at school or during any school activity.

We understand that the school reserves the right to dismiss any student who does not respect and maintain the school's spiritual and academic standards.

We have read the religious instruction section of the student handbook and agree to these concepts being taught to our child.

We agree that if our child should become involved in any trouble or if we disagree with any policy set by the school, we will in no case complain to any other party, and in the spirit of meekness, will register only necessary complaints with the teacher or administration (Matthew 18:15-17). If the complaint is with a teacher, we will go directly to that teacher before taking the complaint to the administration.

We understand that assessments will be made to cover damage to school property (including window breakage, abuse of books, etc). We understand also that some fees may be charged for courses or activities that require extra financial expense.

We agree to pay all of our financial obligations to Liberty Christian School Redding on or before the due date. Financial obligations shall include, but are not limited to, tuition as set forth in the tuition schedule. We understand that our annual tuition is payable in ten (10) equal monthly installments. The first tuition payment is **due on August 1st**.

We understand that all tuition payments are due and payable on the first of each month. If payment is not received by the 5th of the month, your account on file will be charged. Unpaid balances will incur a late fee.

**LIBERTY CHRISTIAN SCHOOL
STUDENT HEALTH RECORD**

PLEASE PRINT THE REQUESTED INFORMATION BELOW.

Date: _____

Student's Name: _____
Last
First
Middle

Grade: _____ Sex: _____ Birth Date: _____

PAST MEDICAL HISTORY

| | Yes | No | Date | | Yes | No | Date |
|------------------------|-----|----|------|-----------------------------|-----|----|------|
| Asthma | | | | Tuberculosis | | | |
| Chickenpox | | | | Rheumatic Fever | | | |
| Mumps | | | | Heart Trouble | | | |
| Scarlet Fever | | | | Sore Throats/Frequent Colds | | | |
| Whooping Cough | | | | Ear Trouble | | | |
| Pneumonia | | | | Hay Fever/Allergies | | | |
| Infectious Hepatitis | | | | Allergic to any Medications | | | |
| Epilepsy/Convulsions | | | | Diabetes | | | |
| Allergic to Bee Stings | | | | Other | | | |

Surgery, injuries or allergies that require medication at school _____

Does your child stutter, stammer or lisp? Yes _____ No _____
 Does your child have a physical handicap? Yes _____ No _____
 Does your child have a hearing difficulty? Yes _____ No _____
 Does your child wear glasses? Yes _____ No _____ Reading only? Yes _____ No _____ Last Exam? _____
 Does your child wear contact lenses? Yes _____ No _____
 Has your child ever been hospitalized overnight? Yes _____ No _____ Date: _____
 For what? _____

Has your child ever had surgery? Yes _____ No _____ Date: _____
 Type of surgery? _____

Should activity be restricted for any reason? (written Doctor's authorization required) _____

Is your child presently taking any medication? Yes _____ No _____
 Name of medication and reason _____

Do you have any health concerns you wish to discuss with the administration? Yes _____ No _____
 Explain _____

 Signature of Parent/Guardian

Dear Liberty Christian Families,

All registrations require the submission of each Authorization form. **Payments are due on the 1st day of each month. If payment is not received by the 5th of the month, your account on file will be charged.** *Overdue accounts will be assessed a late fee on the unpaid balance. It is important that tuition is paid on schedule to assure the school's ability to meet its financial obligations.*

In the case of families who do not have an ACH form, both first and last month's tuition is due before your student can begin school. Your signature on the enrollment application indicates you understand and agree to these terms. Thank you!

Debbie Signor

Principal

Liberty Christian School



ACH Payment Authorization

You authorize regularly scheduled charges to your checking/savings account. You will be charged for each service below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Liberty Christian School Redding to charge my
(Full Name)
bank account indicated below for:

___ Tuition (Monthly on ___ day of the month ___ Aug - May or ___ June - May)
___ Daycare ___ Enrollment Fee (At Enrollment) ___ Curriculum Fee (June 1st)

Additional Instructions: _____

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Bank Details

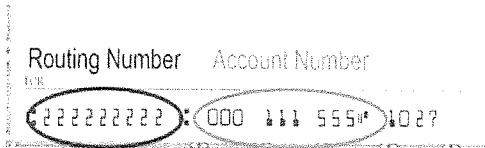
Checking Savings

Account Name _____

Bank Name _____

Account Number _____

Routing Number _____



I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Liberty Christian School Redding in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Liberty Christian School Redding may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____
(Account Holder's Signature)

DATE _____

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/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHThERIA ONLY) DT/Td | / / | / / | / / | / / | / / |
| 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.

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

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

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

| | | |
|------------|-------------------|-----------------------------|
| WALKED AT* | 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 | 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? YES NO HOW MANY IN LAST YEAR? _____ LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF _____

DAILY ROUTINES (*For infants and preschool-age children only)

| | | |
|---|--|--|
| WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?* |
| DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?* |
| DIET PATTERN: (What does child usually eat for these meals?) | BREAKFAST _____ LUNCH _____ DINNER _____ | WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____ |

ANY FOOD DISLIKES? _____ ANY EATING PROBLEMS? _____

| | | | |
|--|-------------------------|--|----------------------|
| IS CHILD TOILET TRAINED?* | 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 |
|--------------------|------|

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

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

DATE OF ADMISSION

DATE LEFT

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: Department of Social Services

Licensing Office Address: Chico, CA

Licensing Office Telephone #: 530-895-5033

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

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.

Liberty Christian Preschool
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

LIC 995 (9/08)

PERSONAL RIGHTS**Child Care Centers**

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

| | | |
|---------------------------------------|-------------------|--|
| NAME Department of Social Services | | |
| ADDRESS 520 Cohasset Rd | | |
| CITY Chico | 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) Liberty Christian School | (PRINT THE ADDRESS OF THE FACILITY) 2970 Hartnell Ave Redding, CA 96002 |
| (PRINT THE NAME OF THE CHILD) | |

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

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, 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://ccl.dss.cahwnet.gov/RegionalOf_1829.htm