

Preschool Application Check List

2023-2024 - **New student applications accepted starting January 16, 2023 to January 31, 2023**

In order to accept your child's application for Preschool, the following forms must be **completed** and returned by deadline

ONLY COMPLETED APPLICATIONS WILL BE ACCEPTED

Form #1 _____ Application Form – Attach the \$100.00 non-refundable Application Fee made payable to Hillsborough Recreation to this application along with the nonrefundable \$650.00 Admission Fee

Form #2 _____ I.D. and Emergency Information

Form #3 _____ Consent for Medical Treatment

Form #4 _____ Student Accident Coverage

Form #5 _____ Health History – Parent Report

Form #6 _____ **NEW STUDENTS ONLY/unless returning students have updates**
Physician's Report – Must be filled out and signed by your child's physician and returned with application.
Required Vaccines to meet the childcare immunization requirements:

- ✓ **Three doses of polio**
- ✓ **Four doses of DTP/DTaP**
- ✓ **One dose of MMR**
- ✓ **One Dose of Hib**
- ✓ **Three doses of hepatitis B**
- ✓ **One dose of varicella**

Form #6A _____ Read and Review

Form #7 _____ Notification of Parents' Rights

Form #8 _____ Personal Rights

Form #9 _____ Behavior Standards

Form #10 _____ Photo Consent/HTV Permission

Form #11 _____ Parent Consent for Administration of Medications and Medication Chart

Form #12

and 12A _____ FARE (If your child has allergies please fill out , if no known allergies leave blank)

Copy of: _____ **Birth Certificate** **All new students must provide a copy of their Birth Certificate**
an application is considered incomplete without a copy of your child's birth certificate

New applications accepted continuously

The Hillsborough Preschools
Tuition and Fee Schedule 2023-24

Program	Application Fee All Students	Admission Fee New Students Only	*Two Pay Plan June/Jan (Yearly)	*Nine Pay Plan 9 months (Yearly)
RESIDENTS				
Preschool (3 day)	100	650	3,600 (7,200)	848 (7,632)
Preschool (5 day)	100	650	5,775 (11,550)	1,360 (12,243)
Pre-K/TK (5 day)	100	650	5,775 (11,550)	1,360 (12,243)
NON RESIDENTS				
Preschool (3 day)	100	650	3,825 (7,650)	901 (8,109)
Preschool (5 day)	100	650	6,169 (12,338)	1,453 (13,078)
Pre-K (5 day)	100	650	6,169 (12,338)	1,453 (13,078)

***Two Payment Plan:**

Due on: June 1, 2023 and January 1, 2024

***Nine Payment Plan: Due by the 1st of each month**

Due: June, Sept., Oct., Nov., Jan., Feb., March, April and May

****Please write your child's name, school site and program on the bottom of your check***

Keep this form as your reference for payment due dates.

If payment has not been received by the 10th of the month in which it is due a \$5 per calendar day late fee (per student) will be applied from the 1st of the month.

Application Fee	Non-refundable fee for all students – due with application
Admission Fee	An admission fee of \$650 for each new preschool student is due with application. This fee is non-refundable. <i>(deduct fee from amount due for first tuition payment)</i>
15% Sibling Discount	Applied to the lower program tuition
Withdraw Policy	A withdraw fee of \$650 will be applied to prorated tuition.

NO TUITION ADJUSTMENT WILL BE MADE FOR VACATIONS, ILLNESS, OR IF A STUDENT IS ELIGIBLE FOR SERVICES THROUGH HILLSBOROUGH SCHOOL DISTRICT OR OTHER TIME OFF.

Tuition Statements will be emailed with payment directions - check and credit card payments are accepted *(fees will apply to credit card payments)*



The Hillsborough Preschools

Application for school year 2023 - 2024



First Choice _____ Second Choice _____ Third Choice _____

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> New Resident Preschooler | <input type="checkbox"/> Hillsborough Public Employee/HCSO Employee |
| <input type="checkbox"/> Sibling of Current Resident Preschooler | <input type="checkbox"/> Sibling of Current Non-resident Preschooler |
| <input type="checkbox"/> Sibling of Resident K-5 Student | <input type="checkbox"/> New Non-resident Preschooler |
| <input type="checkbox"/> Sibling of Alumni | <input type="checkbox"/> Returning Preschooler |

Name of Child _____ Birth Date _____ Boy _____ Girl _____
 Address _____ City _____ Zip _____
 Telephone _____ Email Address _____
 Name of Parents Mother: _____ Cell # _____
 (Or guardians): Father: _____ Cell # _____

Name I would like my child to be called at school: _____

All children must be fully toilet trained. Younger children may be accepted on a space available basis and at the Recreation Department's discretion.

To pick a class choose where your child's birthdate falls and then pick location **(circle one)**:

Class*	Location	Birthdate	Days	Time
Preschool	North, South, West	12/2/20 – 2/3/21	M W F (limited spaces)	8:30 – 11:30
Preschool	North, South, West	9/2/19 – 12/1/20	M – F	8:30 – 11:30
Prekindergarten	North, South, West	2/3/19 – 9/1/19	M - F	12:30 – 3:30
Transitional Kindergarten	TBD	Already registered in HCSO TK program	M – F	12:30 – 3:30

*See next page for Class description

A non-refundable application fee of \$100.00 must accompany this application.
All new students must include the \$650 Admission Fee.

Review the tuition payment plan attached. **Circle the payment plan selected:**

1. Two payment plan 2. Nine payment plan

Parent Signature: _____ Date: _____

We are excited to get the word out about Hillsborough Recreation and you are a valuable partner, we would like to purchase you a sweatshirt to wear as a parent.

Please select size Adult: Small Medium Large XLarge XXLARGE

How did you hear about our program? _____

***For more information contact Hillsborough Recreation**

3-Day Preschool







If your child was born between 12/2/2020 and 2/3/2021, you may enroll in our 3-day preschool program. This program will work in conjunction with our 5-day preschool program. In the Preschool program, the children participate in a full complement of developmentally appropriate activities including arts and crafts, manipulatives, dramatic play, songs, stories, fingerplays, and large motor activities both indoors and out. We also introduce basic scientific, sensory, and physical concepts, beginning math skills, upper case alphabet, and an introduction to vocal and instrumental music of different cultures. A hallmark of our program is to foster and nurture social and emotional growth while recognizing that each child is an individual and grows and develops at their own pace.

5-Day Preschool

If your child was born between 9/2/2019 and 12/1/2020, you may enroll in our 5-day preschool program. This program will work in conjunction with our 3-day preschool program. In the Preschool program, the children participate in a full complement of developmentally appropriate activities including arts and crafts, manipulatives, dramatic play, songs, stories, fingerplays, and large motor activities both indoors and out. We also introduce fine motor skills, basic scientific concepts, sensory, and physical concepts, beginning writing skills, spelling and name recognition, and an introduction to vocal and instrumental music of different cultures. A hallmark of our program is to foster and nurture social and emotional growth while recognizing that each child is an individual and grows and develops at their own pace.

Pre-K/Afternoon TK

If your child was born between 2/3/2019 and 9/1/2019 or your child is registered and currently attending the HCSD Transitional Kindergarten (TK) program, you may enroll in our Pre-K/Afternoon TK program. These are students who will transition together next year in Kindergarten. The Pre-Kindergarten program is a natural progression of learning for children who are in their final year of preschool. Pre-Kindergarten readiness skills are emphasized, including, but not limited to upper and lower case alphabet, age-appropriate mathematical concepts, writing skills, and pre-reading skills, as well as a broad appreciation of nature, science, art, cooking, and continuation of the exploration of music. All activities are conducted in a friendly, encouraging atmosphere that allows learning to take place at the child's own pace. A hallmark of our program is to foster and nurture social and emotional growth while recognizing that each child is an individual and grows and develops at their own pace. In addition, our teachers work closely with the school staff and kindergarten teachers to ensure that our program provides a solid foundation for the transition into any elementary school.

HILLSBOROUGH RECREATION PRESCHOOL PROGRAM PROGRESSION			
	2023/2024 SCHOOL YEAR	2024/2025 SCHOOL YEAR	2025/2026 SCHOOL YEAR
BIRTHDATE: 12/2/20 - 2/3/21	3 DAY PRESCHOOL 	5 DAY PRESCHOOL 	PRE - K / T.K. 
BIRTHDATE: 9/2/19 - 12/1/20	5 DAY PRESCHOOL 	PRE - K / T.K. 	KINDERGARTEN
BIRTHDATE: 2/3/19 - 9/1/19	PRE - K / T.K. 	KINDERGARTEN	FIRST GRADE

IDENTIFICATION AND EMERGENCY INFORMATION **CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**

FORM #2

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BIRTHDATE	BUSINESS TELEPHONE ()
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	HOME 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 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
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

FORM #3

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

The Hillsborough Preschool (North, South, West) _____ 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

NAME _____ . THIS CARE MAY BE GIVEN UNDER _____

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

()

STUDENT ACCIDENT COVERAGE

One alternative must be checked.

() My son/daughter is currently covered by Pacific Educators Student Insurance, 24 hour plan, purchased through the Hillsborough City School District.

() My son/daughter is currently covered by _____.
(Your current Health Insurance) Name of Insurance

I hereby absolve Hillsborough Recreation, its employees and officers from all liability that may arise as a result of my child's participation in the Hillsborough Preschool. I hereby give permission for his/her participation as indicated and in so doing absolve Hillsborough Recreation, its employees and officers from such liability.

SIGNED: _____ DATE: _____
Signature of Parent/Guardian

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**FORM #5**

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
<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

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

FORM #6

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.

**CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS**

FORM #7

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: PENINSULA REGIONAL OFFICE - CHILD CARE
Licensing Office Address: 801 TRAEGER AVENUE, SAN BRUNO, CA. 94066
Licensing Office Telephone #: 650-266-8843

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.

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

FORM #8

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

PENINSULA REGIONAL OFFICE - CHILD CARE

ADDRESS

801 TRAEGER AVE, SUITE 100

CITY

SAN BRUNO

ZIP CODE

94066

AREA CODE/TELEPHONE NUMBER

650-266-8843

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)

Dear Parents,

An important focus of the Hillsborough Preschool program is the continued development of the social skills and self-discipline necessary for the child to function successfully in small and large groups. At this point in the child's development, he/she should be acquiring a collection of strategies for handling problems and getting along with other children. Inappropriate reactive behaviors such as hitting, kicking, or biting should be discarded in favor of strategies such as talking out problems and requesting adult assistance.

Here at Hillsborough Preschool, no child may:

**Hurt another in any way
Disrupt the work of another
Misuse the materials or equipment**

We recognize that children mature at different rates and that they develop these positive social skills over time. However, to make the most productive use of the group's class time, the following process has been developed for use with those children who exhibit the inappropriate behaviors listed above:

- 1. Removal from the group and/or activity for a limited period.**
- 2. Counseling with the teacher and/or director. A conference will provide an opportunity for the exchange of ideas on how to help the child.**
- 3. A probationary period of one to two weeks.**

In order to guarantee a quality experience for the total group, students who repeat these behaviors may be removed from the preschool program and their fees refunded.

Thank you,
Hillsborough Recreation

This will acknowledge that I/we, the parents of _____

Have read the above statement regarding behavior standards.

Parent/Guardian Signature

Date

Hillsborough Preschool

Photo Consent

During the school year, we will be having many fun and exciting activities and experiences. We would like to document/share these activities by photographing and/or filming the students. Teachers and parents will be the photographers/videographers. We need your support and agreement to allow us to do this. The pictures/filming will be done during classroom activities, field trips etc. The pictures may be posted at school, used in a newsletter, slideshows, poster board displays, our school web community, school projects, our classroom photo website, publications/ads for the Hillsborough Preschools, class yearbook, and student memory albums/video and on our **Hillsborough Recreation web site and/or Hillsborough Recreation seasonal Catalog**. We will not include your child's last name (*with the exception of the yearbook*), address, phone number or personal info when sharing/using the photos/film.

_____ Yes you may photograph/film my child for the purposes stated above.

_____ No you may not photograph/film my child.

Childs Name _____

Parent/Guardian Signature _____ Date _____

HTV Permission

Hillsborough Educational Television (HTV) is our local cable station shown on Cable Channel 27 only in the Town of Hillsborough. (HTV is not available on satellite). Parents, students, volunteers, and staff members will be filming student performances, presentations, and activities throughout the school year for viewing on HTV. HTV has strict guidelines to protect the privacy of our students. While your child's image may appear on HTV, programming does not include children's last names, addresses or telephone numbers. All programs pass through a multi-step review process before they are cablecast.

_____ Yes I give permission for my child to be filmed for HTV

_____ No I do not give permission for my child to be filmed for HTV

Childs Name _____

Parent/Guardian Signature _____ Date _____

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART**NOTE:** Regulation Section 101221 requires the following information be on file.

CHILD CARE CENTER NAME:	LICENSE NUMBER: North 410709659 South 410518278 West 410518279	DATE:
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PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME	DOSAGE

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From _____ to _____ at _____ daily while in attendance.

BEGINNING DATE ENDING DATE TIME OF DAY

PARENT'S SIGNATURE:	DATE:
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MEDICATION CHART
Staff Documentation of Medicine Administration

DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE

Upon completion, return medicine to parent or destroy, and place form in child's record.

STAFF	DATE
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FARE
 Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

 Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

 PLACE
 PICTURE
 HERE

NOTE: Do not depend on antihistamines or Inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS


LUNG

 Short of breath,
 wheezing,
 repetitive cough

HEART

 Pale, blue,
 faint, weak
 pulse, dizzy

THROAT

 Tight, hoarse,
 trouble
 breathing/
 swallowing

MOUTH

 Significant
 swelling of the
 tongue and/or lips

SKIN

 Many hives over
 body, widespread
 redness

GUT

 Repetitive
 vomiting, severe
 diarrhea

OTHER

 Feeling
 something bad is
 about to happen,
 anxiety, confusion

**OR A
 COMBINATION**
 of symptoms
 from different
 body areas.


- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS


NOSE

 Itchy/runny
 nose,
 sneezing

MOUTH

Itchy mouth


SKIN

 A few hives,
 mild itch

GUT

 Mild nausea/
 discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
 SYSTEM AREA, GIVE EPINEPHRINE.**
**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
 AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

 Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., Inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

**FARE**

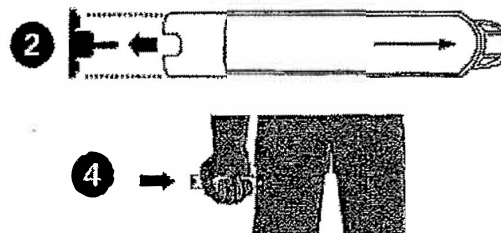
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

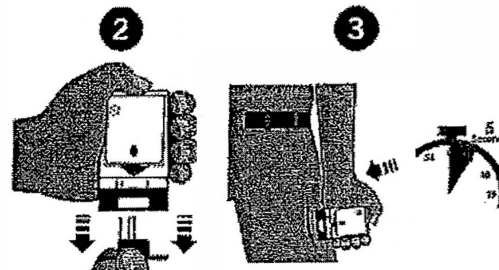
Form # 12A

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.

**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

**ADRENALCLICK®/ADRENALCLICK® GENERIC DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____

DATE _____