Received by: _____ Date: _____

MISSION CHILD CARE CONSORTIUM, INC.

4750 Mission Street, San Francisco, CA 94112
Tel: (415) 586-6139 Fax: (415) 586-2339

Non-Discrimination Policy VI Opportunity and Equal Education Access. The Mission Child Care Consortium, Inc. Is an equal opportunity employer and does not discriminate against its services to anyone because of sex, sexual orientation, gender, ethnic group, identification, race, ancestry, national origin, religion, color, or mental or physical disability. The Mission Child Care Consortium, Inc. practices a policy of non-discrimination and affirmative action in employment and does not discriminate to qualified person because of sex, sexual orientation, gender, ethnic group, identification, race ancestry, national origin, religion, color or mental or physical disability.

PRE-REGISTRATION FORM FOR CHILD DEVELOPMENT PROGRAM
FORMULARIO DE PREINSCRIPCIÓN/PROGRAMA DE DESARROLLO DEL NIÑO

Date *(Fecha)*: _____

Child's Name *(Nombre del niño/a)*: _____

Birth Date *(Fecha de Nacimiento)*: _____ **Sex(*Sexo*):** **F** ☐ **M** ☐

Father's Name *(Nombre del papá)*: _____

Home #: _____ **Cellphone #:** _____ **Work #:** _____

Email: _____ **Occupation *(Ocupacion)*:** _____

Mother's Name *(Nombre de la mamá)*: _____

Home #: _____ **Cellphone #:** _____ **Work #:** _____

Email: _____ **Occupation *(Ocupacion)*:** _____

Marital Status *(Estado Civil):*

Single *(Soltero/a)* ☐ **Married *(Casado/a)*** ☐ **Divorced *(Divorciado/a)*** ☐ **Separated (Separado*/a)*** ☐

Widow *(Viudo/a)* **No** ☐ ***Married but living together (No casado, pero viven juntos)*** ☐

Home Address *(Dirección de la casa)*: _____

Did your child attend a prior preschool/Home Day Care (*Su hijo/a asistido un preescolar o Guardaría antes?)*

Yes ☐ **No** ☐ **If you marked yes, please name the school and explain:** *(Si marco si, por favor nombre la escuela y expliqué razón):* _____

Has your child received an IEP/IFSP *(Su hijo/a ha recibido un IEP/IFSP?)* **Yes (Si)** ☐ **No** ☐

In Process *(en proceso)* ☐ **If yes please provide documentation *(Si marcó si, por favor traiga documentación)***

Are you in Training or School *(Está usted en un Entrenamiento o en la Escuela)*? **Yes *(Si)*** ☐ **No** ☐

Are you receiving Child Support *(Recibe ayuda de manutención Infantil)*? **Yes *(Si)*** ☐ **No** ☐

Are you receiving Food Stamp or CalFresh *(Recibe ayuda de estampillas de comida)*? **Yes *(Si)*** ☐ **No** ☐

Is your family under, CPS (Child Protective Services) or At Risk? (*Esta su familia bajo los servicios de protección al menor o en riesgo?* Yes *(Si)* ☐ **No** ☐

Are you currently on Incapacity or considered Incapacitated *(En este momento está usted bajo incapacidad o se considera deshabilitada(o))*? Yes *(Si)* ☐ **No** ☐

Is your family receiving AFDC, SSI or SSP *(Usted o su familia reciben ayuda de AFCD, SSI o SSP)*?

Yes *(Si)* ☐ **No** ☐ **Medical Number *(Numero del Medical)*:** _____

If you are not working or going to school are you seeking employment? *(Si no está trabajando o yendo a la escuela, ¿está buscando empleo?)* **Yes *(Si)*** ☐ **No** ☐

Are you seeking permanent housing? ***(****¿Estás buscando vivienda permanente?)* **Yes *(Si)*** ☐ **No** ☐

Father's Employer *(Empleador del Padre)*

_____

Employer's Address *(Dirección de Empleador)*

_____

If employed, I receive income by: Company check, Cash, or Personal check (please check what applies to you). *(Si está empleado, yo recibo ingresos en forma de: Cheque de la Compañía, Efectivo o Cheque Personal: por favor, marque lo que es aplicable para usted).*

☐ *Company Check (Cheque de la Compañía)* ☐ *Cash (Efectivo)* ☐ *Personal Check(Cheque Personal)*

Mother's Employer *(Empleador del Madre)*

_____

Employer's Address *(Dirección de Empleador)*

_____

If employed, I receive income by: Company check, Cash, or Personal check (please check what applies to you). *((Si esta empleado, yo recibo ingresos en forma de: Cheque de la Compañía, Efectivo o Cheque Personal: por favor, marque lo que es aplicable para usted).*

☐ *Company Check (Cheque de la Compañía)* ☐ *Cash (Efectivo)* ☐ *Personal Check (Cheque Personal*

Other children *(Otros niños)*? Yes *(Si)* ☐ **No** ☐

If yes, name/s, date/s of birth and School/s *(Si su respuesta es Si, de los nombre/s, fecha/s de nacimiento y nombre de la Escuela que asisten)*:

Name *(Nombre)*	**Date of Birth *(Fecha de Nacimiento)***	**School *(Escuela)***

Other members of the household *(Otros familiares/personas viviendo en la casa)*?

Yes *(Si)* ☐ **No** ☐

Name *(Nombre)*	**Relationship *(Parentesco)***	**Telephone *(Teléfono)***

ENROLLMENT AND ELIGIBILITY REQUIREMENTS CHECKLIST
LISTA DE REQUISITOS Y DE ELEGIBILIDAD PARA INSCRIPCIÓN

NOTE: **Due to the Hands-Free Policy, a child must be completely toilet-trained to be enrolled at the Mission Child Care Consortium Inc. A child needs to be able to assist him/herself in taking care of their toileting needs. Please attach a copy of the following.**
(Debido a la Política de Manos Libres, un niño/a debe estar completamente entrenado para usar el baño para ser inscrito en Mission Child Care Consortium Inc. Un niño debe ser capaz de asistir a sí mismo en el cuidado de sus necesidades de aseo. Por favor adjunte una copia de los siguientes)

Yes *(Si)* ☐ **No** ☐

☐ **Your child and his/her siblings Birth Certificates**
(Una copia del certificado de nacimiento de su niño/a y de sus hermano/as)

☐ **Physician's Report Form and Most Updated Immunization Record**
(El físico más reciente junto con el récord de vacunas)

☐ **Proof of Residency** ***(Prueba de residencia/domicilio)***

☐ **A Copy of any proof of Residency such as PG&E, Water, Cable TV, Garbage, Home Telephone, Lease Agreement** ***(Una copia de cualquier prueba de residencia como, PG&E, Agua, Cable, Teléfono, Contrato de domicilio).***
*Please see 4th page for further information on documents needed.
**Por favor, consulte la 4ª página para obtener más información sobre los documentos necesarios.*

_____ _____
Father/Legal Guardian/Grandparent Signature **Date**
(Padre/Tutor legal/Abuelos/a Firma) ***(Fecha)***

_____ _____
Mother/Legal Guardian/Grandparent Signature **Date**
(Madre/Tutor legal/Abuelos/a Firma) ***(Fecha)***

Along with your application please provide the following documentation:

A) 1 (One) OF ANY LEGAL, GOVERNMENT ISSUED DOCUMENT, or UTILITY BILL (listed below):

1. Divorce Documents
2. Child Support Documents
3. DMV Car Registration
4. Legal Separations Documents
5. Legal Custody Documents
6. Cal Fresh or Food stamp
7. Cash Aid
8. Medi-Cal
9. CalWORKs
10. EDD/Disability Documents
11. Lease Agreement
12. Residency Verification Form with their address and phone number for verification*

*If none above, please have your Landlord complete a Residency Verification Form and provide one of the following documents with Landlord Name:

- PG & E Bill
- Home Cable Bill
- Water Bill
- Home Phone Bill
- Home Internet Bill
- Garbage Bill

B) All the documents (listed below):

1) Child Birth Certificate
2) Current and updated Immunization Records together with Physician's Report form attached in this packet.

MISSION CHILD CARE CONSORTIUM, INC.
CONSENT AND RELEASE AUTHORIZATION

Child's Name: _____

Upon admission of my child at Mission Child Care Consortium, Inc. I agree and understand the regulations set forth in the center and hereby give full consent to have my child participate in walks, field trips, on public transportation and chartered buses from the center to points of interest in and out of the City limits.

I authorize the Mission Child Care Consortium, Inc. staff to call 911 emergency service in case of an accident or illness if it is a life-threatening situation in need of immediate medical attention if I am not immediately available. It is understood that a conscientious effort must be made to notify me and the agency will follow the medical instructions stated on the Child's Emergency Information Form and this Consent and Release Authorization Form. No medical treatment shall administer at the hospital without parent or doctor's forms.

I agree for my child to be photographed to assist the center with certain activities. I agree and give consent for my child to be videoed for the use of security cameras are inside and outside the facility. A video surveillance system is in place for the safety and security of the children, staff and property.

I understand that I do not hold Mission Child Care Consortium, Inc. responsible or liable for any medical emergency services for my child.

I understand that I will fully pay for medical services or treatment to my child under my medical coverage should my child need treatment. MCCC has medical insurance in case of accident on MCCC premises.

_____ _____
Parent/Guardian's Signature **Date**

_____
Doctor's Name **Address**

_____
Doctor's Phone Number

_____
Hospital or Medical Facility

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
( )	( )

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
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ 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?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST _____
	LUNCH	LUNCH _____
	DINNER	DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ 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

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	TELEPHONE	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