

LAS POSAS CHILDREN'S CENTER, INC at Montalvo School

2022-23 School Year

Prices and Payment Agreement

Prices subject to change if current pandemic guidance reverts back to a more restrictive status

Annual Registration Fee.....\$70.00 (June-June)	
After School Grades 1-8	After School Kindergarten
4-5 Days.....\$104.00 per week	4-5 Days.....\$124.00 per week
3 Days.....\$78.00 per week	3 Days.....\$93.00 per week
2 Days.....\$52.00 per week	2 Days.....\$62.00 per week
*1 Day.....\$26.00 per week	*1 Day.....\$31.00 per week
Hourly.....\$17.00 per hour	Hourly.....\$17.00 per hour
* IMPORTANT: 1 Day rate and Hourly rate not available for Wednesdays	
<i>Additional Child Discount (Minimum 3 days per week).....\$5.00</i>	
School Holiday/Inservice Day	\$15 over and above regular tuition
Minimum Day	\$ 4 over and above regular tuition

<p>Weekly Fee and Schedule Changes Your WEEKLY FEE is due in advance on the Saturday preceding each week and is charged whether or not your child is in attendance, including COVID quarantine time imposed by us. In effect, you are paying for your spot at Las Posas Children’s Center. If you drop from the program you must wait 4 weeks before re-enrolling or pay your full weekly fee for the weeks you missed.</p>
<p>Payment Due/Late Fee Payments are due on the preceding Saturday for each week. All accounts not paid by 6:00pm Saturday will be assessed a \$10.00 Late Fee.</p>
<p>Subsidized Payments All families whose childcare is paid for by an outside agency, such as <i>Child Development Resources</i> and <i>Children’s Home Society</i> are responsible for all tuitions and fees not covered by the outside agency. Additionally you will be charged \$25.00 if you fail to complete your voucher/time sheet correctly or on time.</p>
<p>Late Pickup Fee LPCC closes at 6:00pm every night. Please do not be late. You will be charged \$10.00 for every 15 minute increment that you are late in picking up your child.</p>
<p>Returned Checks There is a \$30 charge for all returned checks Returned checks that go unpaid will be turned over to the District Attorney’s Office. See <i>Collections</i> below.</p>
<p>Refund Policy No refunds will be given for any reason, including your child being expelled from the program for disciplinary reasons and your decision to drop from the program. Any credit due you will be given in services rendered.</p>
<p>Collections Delinquent accounts that go unpaid will be sent to an outside collection agency and/or the District Attorney’s Office and/or Small Claims Court.</p>
<p>Personal Equipment LPCC will provide all supplies and sports equipment. Children should not bring any such items (animals included) for use unless given permission by a staff member. LPCC is not responsible for lost or stolen items</p>
<p>Photographic Release I, the undersigned parent/legal guardian, do hereby authorize the Las Posas Children’s Center to take photographs, videos, motion pictures, and/or sound recordings of my child and/or any other member of my family. I further grant the Las Posas Children’s Center permission to use the photographs, videos, motion pictures and or sound recordings in its general publicity and campaign materials.</p>

The State Dept. of Social Services has the right to perform the duties described in Section 101200 (b) and (c) of the Health and Safety Code.

You acknowledge that you have read this **PAYMENT AGREEMENT** and agree to abide by its terms. You further understand that your child(ren) can be expelled from the program if the policies are not followed.

**LAS POSAS CHILDREN'S CENTER, INC.
HEALTH & SAFETY POLICIES**

HEALTH POLICIES

- If your child is directly exposed to, or tests positive for, COVID-19, he/she cannot attend LPCC until the required quarantine period has elapsed.
- If your child should become ill during the day he/she will be isolated until a parent or authorized person picks him/her up. Pickup must be immediate. Any child sent home for illness cannot attend LPCC for at least 72 hours.
- We ask your cooperation in reporting any contagious condition to a staff member. You MUST immediately report exposure to COVID-19 by anyone in your household to a staff member.
- You will be notified immediately if your child is injured and requires medical attention beyond basic first aid. A seriously ill or injured child will be taken to the nearest emergency medical facility. Every attempt will be made to contact a parent before the trip is made.
- Please send a filled water bottle with your child's name on it every day. Refills can be made safely at the water dispensing station. The drinking fountains may be shutoff.

MEDICATIONS

We can administer medication to your child. All medications must have a doctor's note. A prescription bottle is acceptable as a doctor's note. You must complete and sign a *Medication Request and Record Form*.

SAFETY POLICIES

School Dismissal Procedure

When school is dismissed for the day, kindergartners will be escorted from their school classroom to LPCC by our staff. Children in grades 1-8 will NOT be escorted to LPCC. They are expected to arrive promptly on their own, within 10 minutes of their school dismissal time. You will be called if your child does not arrive by then.

All children are expected to follow the basic Las Posas Children's Center rules to ensure that all children and staff have a positive camp/daycare experience.

1. Keep your hands and feet to yourself. (*No fighting*).
2. Stay with *your* counselor or other staff member at all times.
3. Do your best to keep social distancing of 6 feet when applicable.
4. Rocks, sticks, sand, etc. stay on the ground. (*No rock throwing*).
5. Keep your language clean. (*No cussing*).
6. Say only nice things to others. (*No teasing or name calling*).
7. Tell a staff member instead of retaliating against another child.
8. Respect the property of others and the property of Las Posas Children's Center, Inc. and Ventura Unified School District.
9. No firearms, weapons, alcohol, drugs, pornography and the like.
10. Respect and obey the staff.

These policies will be explained to the children. We ask that you also go over them at home. You may be asked to pick up your child immediately if your child disregards these policies. Your child may be expelled from the program if the policies are continually disregarded.

You acknowledge that you have read the **Health & Safety Policies** and have reviewed them with your child(ren). You further understand that your child(ren) can be expelled from the program if the policies are not followed.

PERSONAL RIGHTS

All children receiving services from Las Posas Children's Center, Inc. shall have rights which include, but are not limited to, the following:

1. To be accorded dignity in his /her 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 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 the daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

4. To have his/her parent/guardian informed of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the licensing agency's complaint receiving unit, 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.
6. Not to be locked in any room, building, or facility premises.
7. Not to be placed in any restraining devices without advance approval of the licensing agency.

Complaints about this facility should be forwarded to:

State Department of Social
Services
6500 Hollister Avenue
Goleta, CA 93117
(805) 562-0400

You acknowledge that you have been advised of, and have received a copy of, your child's **"PERSONAL RIGHTS"** at the time of your child's admission to Las Posas Children's Center, Inc.

Parent's Rights

This form is intended to meet the requirement of California Health and Safety Code Section 1596.857 which requires that parents or guardians be informed of their right to enter and inspect the child care facility in which their children are receiving care. The facility is also required to post notice of this right in an area accessible for viewing. The child care facility is required to give the parent or guardian this form and complete the bottom section of the form and maintain in the child's file to document proper notification.

1. Parents/guardians, upon presentation of identification, have the right to enter and inspect the child day care facility, in which their child(ren) are receiving care, without advance notice to the provider. Entry and inspection is limited to the normal operating hours while their child(ren) is receiving care.
2. The law prohibits discrimination or retaliation against any child or parent /guardian for exercising their right to inspect.
3. The law requires that parents/guardians be notified of their right to enter and inspect.
4. The law requires that this notice of parent's right to enter and inspect be posted in the facility in a location accessible to parents/guardians.
5. The law authorizes the person in charge of the facility to deny access to a parent/guardian under the following circumstances:
 - a) The parent/guardian is behaving in a way which poses risk to the children in the facility, or
 - b) The adult is a noncustodial parent and the facility has been requested in writing by the custodial parent not to permit access to the noncustodial parent.

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 childcare by licensing childcare centers and family childcare homes. Our highest priority is to be sure that children are in safe and healthy childcare settings. California law requires a background check for any adult who owns, lives in, or works in a licensed childcare 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 childcare home or center unless approved by the Department. This approval is called 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 childcare 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 childcare 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 parents or authorized representative of a child in licensed childcare, you have the right to ask the licensed childcare 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 childcare 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://cclid.ca.gov/docs/maps/state.htm>

No Cell Phone and Digital Camera Policy

Children cannot bring cell phones and digital cameras to LPCC. There are several reasons for this. Cell phones and digital cameras are valuable and can get lost, stolen, or broken. Cell phones are a distraction and tend to disrupt the camp activities. Children will make phone calls and send text messages to other campers and friends. Children will put on head phones and choose to not participate in camp activities. Some parents have opted out of having their children appear on social media. And most importantly, we don't want hurtful, embarrassing, or harmful pictures taken of children.

We understand you may want your child to have a cell phone so you can get hold of him/her when you need to, but you can call our camp anytime and we will bring your child to the phone or give him/her a message for you.

You acknowledge that you have read the **No Cell Phone and Digital Camera Policy** and will not allow your child(ren) to bring a cell phone or digital camera to LPCC. You further understand that your child(ren) can be expelled from the program if the policies are not followed.

~~~~~  
In addition to the above policies, You, the natural parent/ legal guardian authorize the following:

1. Your child's participation in the Las Posas Children's Center, Inc. program and all its activities.
2. Las Posas Children's Center, Inc. and its staff to provide transportation to and from related Children's Center/Camp activities.
3. Las Posas Children's Center, Inc., its staff, and ambulance to provide necessary emergency transportation.
4. Las Posas Children's Center, Inc. staff to provide basic first aid treatment.
5. Any Physician or the medical staff of a licensed hospital or clinic to provide treatment as is necessary until I can be notified. I understand this authorization is given in advance of any treatment being required.

You also understand that there is risk involved with respect to such activities and will assume responsibility and will indemnify, hold harmless and defend the Las Posas Children's Center, Inc., its staff, its officers, and its agents against any claim brought on behalf of my minor child in connection with this program. This authorization will remain effective during the enrollment period of this child, unless sooner revoked in writing to said agent.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child(ren)'s Names

\_\_\_\_\_  
Date

**LAS POSAS CHILDREN'S CENTER**  
**at MONTALVO SCHOOL**  
**SCHOOL YEAR 2022-23**  
**REGISTRATION FORM**

| Children's Names | Grade in SY 2022-23 | Daily Or Hourly | Specify Days (√) |   |   |    |   |
|------------------|---------------------|-----------------|------------------|---|---|----|---|
|                  |                     |                 | M                | T | W | Th | F |
|                  |                     |                 |                  |   |   |    |   |
|                  |                     |                 |                  |   |   |    |   |
|                  |                     |                 |                  |   |   |    |   |

**Parent/Guardian 1**

|            |                |                            |            |  |
|------------|----------------|----------------------------|------------|--|
| Name       |                | Relationship to Child(ren) |            |  |
| Home Phone | Work Phone     | Ext                        | Cell Phone |  |
| Email      | Street Address | City                       | Zip        |  |

**Parent/Guardian 2**

|            |                |                            |            |  |
|------------|----------------|----------------------------|------------|--|
| Name       |                | Relationship to Child(ren) |            |  |
| Home Phone | Work Phone     | Ext                        | Cell Phone |  |
| Email      | Street Address | City                       | Zip        |  |

**Emergency Contact Other Than Parent**

|      |            |            |            |
|------|------------|------------|------------|
| Name | Home Phone | Work Phone | Cell Phone |
| Name | Home Phone | Work Phone | Cell Phone |

Persons other than Parents and Emergency Contacts who are authorized to pick up your child from Las Posas Children's Center

|  |
|--|
|  |
|--|

**Las Posas Children's Center, Inc.**  
 Child Emergency Information, Health History,  
 & Medical Release

Page 1 of 2

|              |               |     |
|--------------|---------------|-----|
| Child's Name | Date of Birth | Sex |
|--------------|---------------|-----|

Parent/Guardian 1

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Parent/Guardian 2

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Emergency Contact Other Than Parent

|      |            |            |            |
|------|------------|------------|------------|
| Name | Home Phone | Work Phone | Cell Phone |
| Name | Home Phone | Work Phone | Cell Phone |

Known allergies \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

I, the natural parent/ legal guardian of \_\_\_\_\_ authorize the following:

1. My child's participation in the Las Posas Children's Center, Inc. program and all its activities.
2. Las Posas Children's Center, Inc. and its staff to provide transportation to and from related Children's Center activities.
3. Las Posas Children's Center, Inc., its staff, and ambulance to provide necessary emergency transportation.
4. Las Posas Children's Center, Inc. staff to provide basic first aid treatment.
5. Any Physician or the medical staff of a licensed hospital or clinic to provide treatment as is necessary until I can be notified. I understand this authorization is given in advance of any treatment being required.

I also understand that there is risk involved with respect to such activities and will assume responsibility and will indemnify, hold harmless and defend the Las Posas Children's Center, Inc., its staff, its officers, and its agents against any claim brought on behalf of my minor child in connection with this program. This authorization will remain effective during the enrollment period of this child, unless sooner revoked in writing to said agent.

\_\_\_\_\_  
 Parent/ Legal Guardian Signature \_\_\_\_\_  
 Date

**Please complete and sign Page 2 of 2**

**Health History** for \_\_\_\_\_

We cannot allow anyone to participate in our camp program until immunization history is completed. **Please submit a copy of current immunization record.**

| <b>Conditions</b>           | <i>(Yes/No)</i> |    | <i>Approx. Dates</i> | <b>Allergies</b> | <i>(Yes/No)</i> |    |
|-----------------------------|-----------------|----|----------------------|------------------|-----------------|----|
| Frequent Ear Infections     | Yes             | No |                      | Hay Fever        | Yes             | No |
| Heart defect/Disease        | Yes             | No |                      | Insect Stings    | Yes             | No |
| Convulsions                 | Yes             | No |                      | Penicillin       | Yes             | No |
| Diabetes                    | Yes             | No |                      | Other drugs      | Yes             | No |
| Bleeding/Clotting Disorders | Yes             | No |                      | Asthma           | Yes             | No |
| Hypertension                | Yes             | No |                      | Other (Specify)  |                 |    |
| Mononucleosis               | Yes             | No |                      |                  |                 |    |

**Diseases**

|                |     |    |  |
|----------------|-----|----|--|
| COVID-19       | Yes | No |  |
| Chicken Pox    | Yes | No |  |
| Measles        | Yes | No |  |
| German measles | Yes | No |  |
| Mumps          | Yes | No |  |

Operations or serious injuries (*type and dates*) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications \_\_\_\_\_

Other diseases \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

For Female: Has this person menstruated?

If not, has she been told about it?

Please list anything about your child that you think we should know. Are there any activities in which you don't want your child to participate?

Parent/Legal Guardian Signature

Date



**Las Posas Children's Center, Inc.**  
 Child Emergency Information, Health History,  
 & Medical Release

Page 1 of 2

|              |               |     |
|--------------|---------------|-----|
| Child's Name | Date of Birth | Sex |
|--------------|---------------|-----|

Parent/Guardian 1

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Parent/Guardian 2

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Emergency Contact Other Than Parent

|      |            |            |            |
|------|------------|------------|------------|
| Name | Home Phone | Work Phone | Cell Phone |
| Name | Home Phone | Work Phone | Cell Phone |

Known allergies \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

I, the natural parent/ legal guardian of \_\_\_\_\_ authorize the following:

1. My child's participation in the Las Posas Children's Center, Inc. program and all its activities.
2. Las Posas Children's Center, Inc. and its staff to provide transportation to and from related Children's Center activities.
3. Las Posas Children's Center, Inc., its staff, and ambulance to provide necessary emergency transportation.
4. Las Posas Children's Center, Inc. staff to provide basic first aid treatment.
5. Any Physician or the medical staff of a licensed hospital or clinic to provide treatment as is necessary until I can be notified. I understand this authorization is given in advance of any treatment being required.

I also understand that there is risk involved with respect to such activities and will assume responsibility and will indemnify, hold harmless and defend the Las Posas Children's Center, Inc., its staff, its officers, and its agents against any claim brought on behalf of my minor child in connection with this program. This authorization will remain effective during the enrollment period of this child, unless sooner revoked in writing to said agent.

\_\_\_\_\_  
 Parent/ Legal Guardian Signature \_\_\_\_\_  
 Date

**Please complete and sign Page 2 of 2**

**Health History** for \_\_\_\_\_

We cannot allow anyone to participate in our camp program until immunization history is completed. **Please submit a copy of current immunization record.**

| <b>Conditions</b>           | <i>(Yes/No)</i> |    | <i>Approx. Dates</i> | <b>Allergies</b> | <i>(Yes/No)</i> |    |
|-----------------------------|-----------------|----|----------------------|------------------|-----------------|----|
| Frequent Ear Infections     | Yes             | No |                      | Hay Fever        | Yes             | No |
| Heart defect/Disease        | Yes             | No |                      | Insect Stings    | Yes             | No |
| Convulsions                 | Yes             | No |                      | Penicillin       | Yes             | No |
| Diabetes                    | Yes             | No |                      | Other drugs      | Yes             | No |
| Bleeding/Clotting Disorders | Yes             | No |                      | Asthma           | Yes             | No |
| Hypertension                | Yes             | No |                      | Other (Specify)  |                 |    |
| Mononucleosis               | Yes             | No |                      |                  |                 |    |

**Diseases**

|                |     |    |  |
|----------------|-----|----|--|
| COVID-19       | Yes | No |  |
| Chicken Pox    | Yes | No |  |
| Measles        | Yes | No |  |
| German measles | Yes | No |  |
| Mumps          | Yes | No |  |

Operations or serious injuries (*type and dates*) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications \_\_\_\_\_

Other diseases \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

For Female: Has this person menstruated?

If not, has she been told about it?

Please list anything about your child that you think we should know. Are there any activities in which you don't want your child to participate?

Parent/Legal Guardian Signature

Date

**Las Posas Children's Center, Inc.**  
 Child Emergency Information, Health History,  
 & Medical Release

Page 1 of 2

|              |               |     |
|--------------|---------------|-----|
| Child's Name | Date of Birth | Sex |
|--------------|---------------|-----|

Parent/Guardian 1

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Parent/Guardian 2

|            |                |                            |            |
|------------|----------------|----------------------------|------------|
| Name       |                | Relationship to Child(ren) |            |
| Home Phone | Work Phone     | Ext                        | Cell Phone |
| Email      | Street Address | City                       | Zip        |

Emergency Contact Other Than Parent

|      |            |            |            |
|------|------------|------------|------------|
| Name | Home Phone | Work Phone | Cell Phone |
| Name | Home Phone | Work Phone | Cell Phone |

Known allergies \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

I, the natural parent/ legal guardian of \_\_\_\_\_ authorize the following:

1. My child's participation in the Las Posas Children's Center, Inc. program and all its activities.
2. Las Posas Children's Center, Inc. and its staff to provide transportation to and from related Children's Center activities.
3. Las Posas Children's Center, Inc., its staff, and ambulance to provide necessary emergency transportation.
4. Las Posas Children's Center, Inc. staff to provide basic first aid treatment.
5. Any Physician or the medical staff of a licensed hospital or clinic to provide treatment as is necessary until I can be notified. I understand this authorization is given in advance of any treatment being required.

I also understand that there is risk involved with respect to such activities and will assume responsibility and will indemnify, hold harmless and defend the Las Posas Children's Center, Inc., its staff, its officers, and its agents against any claim brought on behalf of my minor child in connection with this program. This authorization will remain effective during the enrollment period of this child, unless sooner revoked in writing to said agent.

\_\_\_\_\_  
 Parent/ Legal Guardian Signature \_\_\_\_\_  
 Date

**Please complete and sign Page 2 of 2**

**Health History** for \_\_\_\_\_

We cannot allow anyone to participate in our camp program until immunization history is completed. **Please submit a copy of current immunization record.**

| <b>Conditions</b>           | <i>(Yes/No)</i> |    | <i>Approx. Dates</i> | <b>Allergies</b> | <i>(Yes/No)</i> |    |
|-----------------------------|-----------------|----|----------------------|------------------|-----------------|----|
| Frequent Ear Infections     | Yes             | No |                      | Hay Fever        | Yes             | No |
| Heart defect/Disease        | Yes             | No |                      | Insect Stings    | Yes             | No |
| Convulsions                 | Yes             | No |                      | Penicillin       | Yes             | No |
| Diabetes                    | Yes             | No |                      | Other drugs      | Yes             | No |
| Bleeding/Clotting Disorders | Yes             | No |                      | Asthma           | Yes             | No |
| Hypertension                | Yes             | No |                      | Other (Specify)  |                 |    |
| Mononucleosis               | Yes             | No |                      |                  |                 |    |

**Diseases**

|                |     |    |  |
|----------------|-----|----|--|
| COVID-19       | Yes | No |  |
| Chicken Pox    | Yes | No |  |
| Measles        | Yes | No |  |
| German measles | Yes | No |  |
| Mumps          | Yes | No |  |

Operations or serious injuries (*type and dates*) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications \_\_\_\_\_

Other diseases \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

For Female: Has this person menstruated?

If not, has she been told about it?

Please list anything about your child that you think we should know. Are there any activities in which you don't want your child to participate?

Parent/Legal Guardian Signature

Date