



Enrollment Checklist

- ☐ Identification & Emergency Information
- ☐ Physician's Report
- ☐ Health History
- ☐ Parent's Rights
- ☐ Personal Rights
- ☐ Authorization to Consent to Medical Treatment
- ☐ Application for Enrollment
- ☐ Financial Information and Admission Agreement
- ☐ Parent Volunteer Form



Application for Enrollment 2023-2024

Early Registration Fee \$125.00 (application submitted by March 17, 2023)

Registration Fee \$175.00 (application submitted after March 17, 2023)

Child's Name: _____

First

Middle

Last

Date of Birth: ____/____/____ Church Attended by Child: _____

Email Address: _____@_____._____

Home Address: _____

Telephone: (____) ____ - ____ (____) ____ - ____ (____) ____ - ____

Home

Office/Work

Cell

Father's Name: _____

First

Middle

Last

Father's Occupation: _____

Mother's Name: _____

First

Middle

Last

Mother's Occupation: _____

Names & Ages of Siblings:

Name

Age

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

Home circumstances of which staff should be aware of: _____

_____.

1457 Mable Ave. Modesto, CA 95355 – Phone: (209) 579 4070

Preschool Director: Claudia Davidoff | Phone: (209) 602-7607 Email: claudia.davidoff@gacpreschool.com

www.gacpreschool.com



Mission

*Grace Academy Christian Preschool: Mission with a Purpose
To Educate, Respect and Value Each Individual Child*

It is our goal that all children have a sense of acceptance, significance and well-being during their stay with us. We here at Grace Academy Christian Preschool believe that children respond and navigate best in their own age appropriate environment. Young children learn through intellectual challenges, positive self-esteem and integrative peer play. Our objective is to provide your child with the resources he or she will need to have a successful preschool experience, to feel loved, respected, secure and gain self-confidence.

Financial and Admission Agreement Policies for Grace Academy Christian Preschool 2023-2024

- **Tuition**

- The registration fee is non-refundable.
- Tuition is due by the **5th of each month** and is considered **overdue on the 6th**. A **late fee of \$30.00** is charged after the **8th of each month**. If payments are over one month due, your child will be dismissed from the program and collections will ensue
- There is a **\$25.00 fee** charged for returned checks.
- Refunds are not given due to illnesses, vacations, holidays or in-service days.
- If starting in the middle of the month, a full month charge applies.
- Sibling discounts apply.

Please be advised that Grace Academy Christian Preschool reserves the right to increase or decrease monthly tuition rates upon 30 day written notice of change - including rate change, increase or decrease, late fees or extended care fees.



- **Classes Offered**

- 3-year-old class: students need to be potty trained and at least 2.7 years to attend. Some children enrolling at a younger age will repeat the 3-year-old class to qualify for the 4-year-old class the following year.
- Transitional Kindergarten Program: must be 4 by **Sept. 1st** to attend
- 4-year-old class: must be 4 by **Dec. 1st** to attend

- **Preschool Tuition Rates:**

- **3 Year Old Class**

- *Half Day 8:45 am - 12:30 pm*

- [] 3 days T W TH \$375.00 per month

- *Full Day 8:45 am - 3:00 pm*

- [] 3 days T W TH \$470.00 per month

- **4 Year Old Class**

- *Half Day 8:45 am - 12:30 pm*

- [] 3 days T W TH \$375.00 per month

- [] 5 days M-F \$475.00 per month

- *Full Day 8:45 am - 3:00 pm*

- [] 3 days T W TH \$470.00 per month

- [] 5 days M-F \$650.00 per month

- **TK Program**

- *Half Day 8:45 am - 12:30 pm*

- [] 5 days M-F \$475.00 per month

- *Full Day 8:45 am - 3:00 pm*

- [] 5 days M-F \$650.00 per month

- **Extracurricular Classes**

- [] *STEM Program 12:45pm - 1:15pm (2 days/ week)* \$100.00 per month

- [] *UCmas Brain Math (2 days/ week during class hours)* \$100.00 per month

- **Optional Extended Care Packages**

- Drop off from 7:30am to 8:40am: \$7 per half or full hour

- \$25 flat rate fee per day applies for pick up after class end time



Agreement Policy and Guidelines 2022-2023

I understand that the Admission Agreement Policy states that all children entering the facility must be ambulatory and able to enter and exit the facility without any assistance. **Initials** _____

I understand that my child must be toilet trained to attend Grace Academy Christian Preschool. **Initials** _____

I commit to escort my child(ren) to the class and hand them over to the teacher or assistant. **Initials** _____

I understand that I have to sign in and out with my legal name when I drop off/ pick up my child from school. I accept the penalty of \$25 for any missing sign in/out. **Initials** _____

I understand that the school will only release my child to authorized individuals listed on the “Emergency Form” by presenting their valid IDs. I understand that oral authorization is not acceptable. **Initials** _____

I understand that Grace Academy is a Christian preschool and implies a Christ-centered curriculum, and I will not try to change its curriculum to fit my personal beliefs. **Initials** _____

In the event of any harm or injury to my child(ren), I hereby release Grace Academy Christian Preschool and Holy Apostolic Catholic Assyrian Church of East, its officers, employees, agents, leaders, and members of the School/Elder Board from all claims and causes of action by reason of harm or injury which may be sustained before, during regular, or after school hours activities or as a result of play, disobedience to school rules, off-campus trips; whether on the church/school property, at the activity location, or transportation to or from these activities. **Initials** _____

In the event of a major disaster (earthquake, fire, etc.), I authorize Grace Academy Christian Preschool to use its discretion in evacuation procedures and other care as it relates to my child. **Initials** _____



I understand that every student is required by the California State Department of Health to have his/her immunization record on file in the school office. Student exemptions will be excluded from school in the event of an outbreak of any of the non-immunized diseases. The school participates in and views the online Immunization Registry. For more information, contact Stanislaus County Health Services at 209-558-4816. **Initials** _____

I understand that The State of California has the authority to interview children or staff of adult and child care centers without prior consent. Records can be removed if necessary, for copying. Grace Academy will ensure that provisions are made for examination of all records relating to the operation of the pre-school. **Initials** _____

I understand that The State of California has the authority to observe conditions of the child (children) including conditions that could indicate abuse, neglect or inappropriate placement. **Initials** _____

I understand that all incidents that indicate abuse, neglect or any other threat of harm or emotional disturbance to a child, must be reported to The State of California Licensing Board. **Initials** _____

I understand that the staff of GACP may obtain emergency care if parents or guardians cannot be reached. Parents or legal guardians agree to pay all such costs. **Initials** _____

I understand that if medicine is to be administered to my child, I must fill out and sign a “medicine consent form”. I also understand that medicine must be in the original container and the exact dosage listed as well as the hours between dosages and the last time the medicine was dispensed on the “medicine consent form”. We accept children who use additional medical devices of inhalers or epi-pens. No additional injection devices are approved. Injection accommodations would pose an undue hardship on Grace Academy staff and fundamentally alter the nature of the program. **Initials** _____

I commit to notify the school of any positive Covid-19 cases in my household and follow the CDC guidelines. **Initials** _____

I commit to consider the public's health and keep my child home and have a plan of back up child care if my child was in close contact with a positive COVID case or exhibits COVID symptoms/ tests positive. **Initials** _____



I understand that staff and teachers will continue educating my child remotely in the case of an emergency school closure due to Covid or any other pandemics. I understand that I am financially responsible for the tuition for the period/s that my child is on remote learning. **Initials**

POLICY AGREEMENT -

As the parent/guardian of _____, I have read the above Policy and Guidelines. I understand their contents and hereby agree to these terms and conditions.

Parent/Guardian _____

Signature _____ Date _____



Health Policy

Children may only attend if they are well.

Parents or guardians will be called to take a sick child home.

Your child should not come to school with any of the following symptoms

- ✓ A cold that is more than 3 days old.
- ✓ A sore throat or earache
- ✓ A runny nose not related to allergies
- ✓ A fever of 100.2
- ✓ Diarrhea or vomiting

Reason for Termination

Each of the incidents listed below will be discussed between parent and staff to resolve each matter. Harmful incidents would include:

- ✓ hitting
- ✓ biting
- ✓ scratching
- ✓ kicking
- ✓ spitting

If the child is harmful to him or others and after 3 attempts to resolve the matter with the parents and the staff have failed, termination from the program is necessary.

Withdrawal Policy - If you plan to withdraw your child from the program, the office must receive a letter two weeks prior to the withdrawal date. There is no reimbursement and full tuition is due upon leaving.

I have read and agree to the above policies and am responsible for any and all policies for my child according to the above contract.

Parent/ Legal Guardian Name	Signature	_____/_____/_____ Date
------------------------------------	------------------	-----------------------------------



Parent Code of Conduct

I understand that I am my child's best example in conduct, reverence, respectability and responsibility.

I understand that Grace Academy Christian Preschool is dedicated in showing support to my child and his/her family.

In order to show my cooperation, thankfulness and support;

1. I will set a good example in my own speech and behavior.
2. I will always show respect for the teacher and any other adult in authority in front of my child regardless of what I may think of their actions or say to them in private.
3. I will stop rumors. I will go through the proper channels when I have a problem.
4. I will speak respectfully and with kindness and courtesy to other parents in front of students, especially when there is any disagreement.
5. I will follow the school's rules, calendars, and deadlines even when I may disagree.
6. I will supervise my child at drop off and pick up time.
7. I will supervise my child even when I am socializing outside after pick-up time.

I will abide by this code of conduct while my child is enrolled in Grace Academy Christian Preschool. Also, I will abide by this code of conduct if my child is excused or no longer is attending Grace Academy Christian Preschool and there is a concurring issue that may need to be resolved.

A Parent Code of Conduct was developed by Grace Academy Christian Preschool to uphold our endeavor to provide a safe, loving and respectful atmosphere for all children, staff and parents. Please review this code of conduct with anyone who may be caring for your child. It is also important for your child to understand the importance of respect and care for all.

I have read the Grace Academy Christian Preschool Application for Enrollment, Admissions Packet, and Parent Code of Conduct. I understand and will adhere to my responsibilities and financial obligations regarding all contained in this agreement.

_____/_____/_____
Parent/ Legal Guardian Name _ Date

Parent/ Legal Guardian Signature

1457 Mable Ave. Modesto, CA 95355 – Phone: (209) 579 4070

Preschool Director: Claudia Davidoff | Phone: (209) 602-7607 Email: claudia.davidoff@gacpreschool.com
www.gacpreschool.com



Photo Release Form

I, _____, the parent or legal guardian of _____

☐ grant/ ☐ do not grant Grace Academy Christian Preschool my permission to use the photographs of my child for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

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

Parent/Guardian's Name: _____

Child's Name: _____

Phone Number: _____



Parent Volunteers

We appreciate our parent volunteers at Grace Academy Christian Preschool. Our parent volunteers help to develop the enrichment of our educational program. We are always in need of help in the following areas:

- Driving on field trips
- Volunteer in classrooms (must have current immunizations plus TB)
- Repairing toys and equipment
- Guest speaker for the classroom (dentist, fireman, veterinarian, etc.)

Event help is huge. If you would be interested in being on Grace Academy Christian Preschool Events' Team,

GAPP – Grace Academy Parent Participation, please ✓ the boxes below

- I want to be on the GAPP committee for planning events with special interest in -
 - Would like to be the chair / co-chair for any area
 - Decorations
 - Asking Business for raffle and silent auction donations
 - Clean up
 - Music arrangement for the show
 - Food donations
 - Program ads
 - Videographer and/or Photographer of event

My child's name is _____ and they are enrolled in _____ (teacher).

Your Name: _____ 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

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/ 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’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:

<input type="checkbox"/> Chicken Pox	DATES	<input type="checkbox"/> Diabetes	DATES	<input type="checkbox"/> Poliomyelitis	DATES
<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
---------------------------------	--	------------------------	---

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
--------------------	------

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

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

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	Community Care Licensing		
ADDRESS	1310 E. Shaw Ave		
CITY	Fresno	ZIP CODE	93710
		AREA CODE/TELEPHONE NUMBER	(559)243 -4588

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)
Grace Academy Christian Preschool	1457 Mable Ave, Modesto, CA 95355
(PRINT THE NAME OF THE CHILD)	

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

Grace Academy Christian Preschool

FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

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

()