



**Bright Visions**  
**Early Childhood Center**

**Emergency Treatment Quick Reference Form**

THE FOLLOWING INFORMATION IS REQUIRED FOR BCLC TO OBTAIN EMERGENCY TREATMENT FOR YOUR CHILD.

Child's Name: \_\_\_\_\_

Parent/ Legal Guardian Cell Number: \_\_\_\_\_

Parent/ Legal Guardian Cell Number: \_\_\_\_\_

CHILD'S PRIMARY DIAGNOSIS: \_\_\_\_\_

VISION DIAGNOSIS: \_\_\_\_\_ OTHER DIAGNOSIS: \_\_\_\_\_

PARENT/LEGAL GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_  
City State Zip Code  
Home Phone

PARENT/LEGAL GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_  
City State Zip Code  
Home Phone

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PEDIATRICIAN'S NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

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

DATE OF ADMISSION	DATE LEFT
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**ADMISSION AGREEMENT**

NAME OF CHILD: (PLEASE PRINT) \_\_\_\_\_ DOB: \_\_\_\_\_

<u>EMPLOYMENT INFORMATION</u> (PLEASE PRINT ALL INFORMATION)	
FATHER'S NAME: _____	MOTHER'S NAME: _____
* _____	* _____
EMPLOYER	EMPLOYER
* _____	* _____
ADDRESS	ADDRESS
* _____ *	* _____ *
CITY ZIP	CITY ZIP
* _____ *	* _____ *
HOME PHONE WORK PHONE	HOME PHONE WORK PHONE
EMAIL: _____	Email: _____

**School Enrollment**

CHILD'S ENTRY DATE: \_\_\_\_\_

The Blind Children's Learning Center accepts the above child for enrollment of the present school year.

DAYS: M T W T H F

HOURS: \_\_\_\_\_  
 FROM TO

**Extended Care Enrollment**

CHILD'S ENTRY DATE: \_\_\_\_\_

The Blind Children's Learning Center accepts the above child for enrollment of the present school year into the Extended Care Program.

DAYS: M T W T H F

HOURS: \_\_\_\_\_



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**Consent to Emergency Medical Treatment**

MEDICAL AUTHORIZATION FOR (CHILD'S NAME) \_\_\_\_\_  
(PLEASE PRINT)

I, the parent/legal guardian of the above named minor Child, give full authority to the Blind Children's Learning Center (BCLC) and its officers, employees, and agents to take whatever action they deem is warranted, under the circumstances of the emergency, and to act as agent of the Child and myself, the parent/legal guardian, at my expense, regarding the Child's health and safety. This full authority includes giving permission to a physician, paramedic, and/or health care facility to render medical treatment to the Child, including the giving of medication, medical examinations, X-rays, anesthetic, medical and/or surgical diagnosis and hospital care, when deemed necessary by the attending medical professional. I fully acknowledge, as the Child's parent/legal guardian, that this CONSENT is not given in advance of any specific diagnosis, treatment or health care facility being required.

BCLC Policy No. B-XII provides for the Child's legal representative to prohibit the use of a medical physician's involvement in the medical treatment of the Child, because of a religious faith/other spiritual means. If BCLC has not received a written statement of refusal to obtain a physician's medical assessment, a written statement that no medical care be given to the Child, and a written statement accepting full responsibility for the Child's health, BCLC will put into affect the full authority of providing EMERGENCY MEDICAL TREATMENT, as stated in the first paragraph of this document. The BCLC HOLD HARMLESS AGREEMENT is applicable to this Document.

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I have read and understand fully, all elements of this CONSENT TO EMERGENCY MEDICAL TREATMENT document. I further understand fully that this DOCUMENT is legally binding in all terms presented herein. As Parent/Legal Guardian of above named Child, I represent to you that I am legally authorized to sign this CONSENT TO EMERGENCY MEDICAL TREATMENT.

\_\_\_\_\_  
**SIGNATURE OF PARENT/LEGAL GUARDIAN** \_\_\_\_\_  
**DATE**

BCLC has a series of Policies in place for the safety and health of your Child. You may obtain a copy of any or all of those Policies, upon request.



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**Letter of Refusal for Medical Treatment of a Child**

(Do not use this form if you have signed Form No. LIC 627 and/or BCLC Form No. 300)

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The Blind Children's Learning Center (BCLC) respects the parent/legal guardian's "Rights" to refuse medical treatment of any kind for their Child because of religious faith or other spiritual practice. However, to release BCLC of any responsibility concerning your Child's health and any form of emergency treatment, including seeking the advice of a physician, you, the parent/legal guardian of the Child named below, **MUST** sign this Form 300-R, or provide a written and signed letter including the following information before your Child can be enrolled in any program at BCLC (ref. BCLC Policy No. B-XII):

CHILD'S NAME (PLEASE PRINT) \_\_\_\_\_

As parent/legal guardian of the above named Child, I prohibit the use of any medical treatment, of any form, for my Child because we practice a religious faith/spiritual means that forbids such treatment.

INITIAL \_\_\_\_\_

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As parent/legal guardian of the Child named above, I hereby release the Blind Children's Learning Center of any and all responsibility for the health and emergency/medical assistance or assessment of my Child while in the care and supervision of the Blind Children's Learning.

I, (signature required) \_\_\_\_\_, accept full and total responsibility for the health and welfare of the above named Child.

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



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**Consent for Vision Assessment and Treatment of a Minor**

CHILD'S NAME (PLEASE PRINT): \_\_\_\_\_

A licensed pediatric optometrist with the Southern California College of Optometry, is located at the Early Childhood Center two mornings a week as a training opportunity for residents or interns from the university. A select number of children may be chosen to receive a comprehensive vision assessment at no charge. If you are interested in wait listing your child for this opportunity, please fill out the following information.

Through your consent your Child will receive the benefits of this outstanding Program:

- Has your child's eyes been previously DILATED?    ( ) YES    ( ) NO
- Do we have your permission to DILATE            ( ) YES    ( ) NO
- Would you like to be notified as to the day  
and time of the vision exam so that you may attend? ( ) YES    ( ) NO

I hereby represent to you that I, as parent/legal guardian, am legally authorized to sign this CONSENT FOR VISION ASSESSMENT AND TREATMENT OF A MINOR FORM for the above named Child.

\_\_\_\_\_ DATE: \_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

**CONSENT TO ADMINISTER DIAGNOSTIC TESTING**

The Blind Children's Learning Center (BCLC), employs staff members qualified to administer Diagnostic and Developmental Testing of your Child. These tests generally involve gross motor activities, such as running, hopping, and oral motor activities. The staff may consult with professionals in the administration of DIAGNOSTIC TESTING. The results will be used to develop your Child's individualized program. You, as the parent/legal guardian, will be notified of the approximate time such assessment will take place and you will be informed of the results. You are requested not to attend so that the assessment is independently focused on your Child's abilities without your influence.

I have read and understand the benefits of the CONSENT TO ADMINISTER DIAGNOSTIC TESTING. I represent to you, as the parent/legal guardian, that I am legally authorized to sign this FORM for the Child named above.

\_\_\_\_\_ DATE: \_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN



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Early Childhood Center**

Consent for Administering Non-Prescription Fever/Pain Medication

CHILD'S NAME (PLEASE PRINT) \_\_\_\_\_

may be administered \_\_\_\_\_ of Tylenol if his/her fever is \_\_\_\_\_ or  
DOSAGE DEGREES  
more. The dosage is not to exceed what is recommended by the manufacturer. In accordance  
with Blind Children's Learning Center Policy No. B-XIII the parent/legal guardian will be  
notified of the Child's condition and will request the Child be picked up immediately. The  
Child may not return to BCLC until he/she has been free of fever or pain for 24 hours. If the  
Child is returned before the 24 hour time frame, the Child will not be permitted to enter the  
school.

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I have read, understand, and accept responsibility for the information I have provided in this document. I represent to you that I am legally authorized to sign this CONSENT FOR ADMINISTERING FEVER/PAIN MEDICATION FORM for the above named child.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE: \_\_\_\_\_



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Consent to Release for Use of Videotape, Digital Images and Photographs

CHILD'S NAME (PLEASE PRINT): \_\_\_\_\_

The Blind Children's Learning Center (BCLC) routinely develop publications to inform and invite the public to become involved in BCLC through monetary means, volunteerism, Professional service, in-kind donations, and to obtain grants to aid in the continued BCLC service to those in need of our expertise. Pictures of our enrolled children and stories of their accomplishments play a key role in these activities. Your Consent to use videotape, digital images and/or photographs of your Child is required.

I have read, understand and hereby give my CONSENT to BCLC for the use of my Child's photographs for publicity purposes. I further waive all claims for any damage or compensation for such use of my Child's photographs. I represent to you that I, as parent/legal guardian, am legally authorized to sign this CONSENT FOR RELEASE FOR USE OF PHOTOGRAPHS FORM for the above named Child.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE : \_\_\_\_\_

**CLASS ROSTER**

Many parents want to be able to contact other parents in their child's class for such things as play dates, birthday parties, car pooling, etc. It includes child's name, parent's name, address & phone number. This information is only given to currently enrolled families. Would you like to be included in our Class Roster?

Child's Name: YES/NO      Parent's Name: YES/NO  
Address: YES/NO      Phone Number: YES/NO

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE: \_\_\_\_\_





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Consent for Posting Name For Medical/Safety Awareness

CHILD'S NAME (PLEASE PRINT) \_\_\_\_\_

I give my permission for the above named student to have their first name posted on the school grounds at BCLC. This is for staff awareness of certain medical / safety concerns of the student. The purpose is to protect the student. Example might include: (Johnny has an allergic reaction to nuts.)

I have read and understand the information provided in this document.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
Date



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Release and Authorization for Field Trips

CONSIDERATIONS:

This RELEASE AND AUTHORIZATION FOR FIELD TRIPS is given by the Parent/Legal Guardian on behalf of the Child named above, in consideration for the agreement of the BCLC to provide services to the Child and the Parent/Legal Guardian, and for other good and valuable considerations from BCLC of which are hereby acknowledged. The Parent/Legal Guardian understands that the BCLC would not permit a Child to enroll in the BCLC's programs in the absence of Parent's/Legal Guardian agreement to the terms herein.

ACKNOWLEDGEMENT OF HAZARDS: Representation Concerning Health:

Parent/Legal Guardian acknowledges that the Child's vision impairment and any other impairment condition may result in the Child being susceptible to greater risk of physical injury, which may occur while participating in BCLC programs and/or receiving treatment at BCLC. The risks that may be encountered include, the risk of "Losses" as defined above, accidents, equipment failures, natural conditions, the actions of other children, sickness and acts or omissions of other individuals, or services. The Parent/Legal Guardian also acknowledge that medical attention or care for personal injuries, sickness, or accidents involving the Child may not be immediately available. With full knowledge of the stated risks, Parent/Legal Guardian represents and warrants to the "Releasees" that the Child is in good physical health and that except for his/her visual and/or other impairments that may exist, does not have any physical condition which will interfere with his/her ability to participate in the BCLC programs, including FIELD TRIPS, or endanger his/her health in connection with such programs.

ASSUMPTION OF RISK; RELEASE; COVENANT NOT TO SUE: The Parent represents that the Child is voluntarily participating in the BCLC programs and treatment at the BCLC. THE PARENT/LEGAL GUARDIAN ON BEHALF OF THE CHILD, VOLUNTARILY ASSUMES ALL RISK OF "LOSS", AS DEFINED HEREIN. The Parent/Legal Guardian does hereby release and discharge each and every one of the "Releasees" of any responsibility for, and shall indemnify each of the "Releasees" against and hold them harmless from, any and all "Loss" suffered or incurred by the Child which arise out of, or are in any way connected with the BCLC programs, the activities, in diagnosis, or treatment of the Child by BCLC or its employees or services. The Parent/Legal Guardian, on his/her own behalf and on behalf of the Child, hereby agrees not to sue or bring suit or legal or equitable action against any of the "Releasees" of the matters covered by the foregoing releases and indemnities.

SUCCESSORS AND ASSIGNS; SEVERABILITY; MODIFICATION: The releases and covenants given herein shall be binding upon the Parent/Legal Guardian and Child, and the Child's heirs, assigns, and personal representative. If any of the provisions or any portion thereof of this RELEASE AND AUTHORIZATION FOR FIELD TRIPS shall be held invalid or inoperative, the remaining provisions, or portions thereof, shall nevertheless be given full effect. This RELEASE AND AUTHORIZATION FOR FIELD TRIPS cannot be modified or terminated orally by the Parent/Legal Guardian of the Child.

BY YOUR SIGNATURE, THIS DOCUMENT BECOMES A LEGAL AND BINDING CONTRACT BETWEEN YOU, AND ON BEHALF OF YOUR CHILD, AND BCLC.

I have read and understand fully, all elements of this RELEASE AND AUTHORIZATION FOR FIELD TRIPS FORM. I further understand fully that this FORM is legally binding in all terms presented herein. As Parent/Legal Guardian of the named Child and on behalf of the Child, I wish to voluntarily participate in the BCLC FIELD TRIP Program. I represent to you that I, as parent/legal guardian, am legally authorized to sign for the Child named herein.

SIGNATURE OF PARENT/LEGAL GUARDIAN:

DATE: \_\_\_\_\_



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**Agreement to Hold Harmless**

Child's Name: \_\_\_\_\_

CONSIDERATIONS:

This Hold Harmless Agreement is given by the Parent/Legal Guardian on behalf of the Child named above, in consideration for the agreement of the BCLC to provide services to the Child and the Parent/Legal Guardian, and for other good and valuable considerations from BCLC of which are hereby acknowledged. The Parent/Legal Guardian understands that the BCLC would not permit a Child to enroll in the BCLC's programs in the absence of Parent's/Legal Guardian agreement to the terms herein.

ACKNOWLEDGEMENT OF HAZARDS

Parent/Legal Guardian acknowledges that the Child's vision impairment and any other impairment condition may result in the Child being susceptible to greater risk of physical injury, which may occur while participating in BCLC programs and/or receiving treatment at BCLC. The risks that may be encountered include, the risk of "Losses" as defined above, accidents, equipment failures, natural conditions, the actions of other children, sickness and acts or omissions of other individuals, or services. The Parent/ Legal Guardian also acknowledge that medical attention or care for personal injuries, sickness, or accidents involving the Child may not be immediately available. With full knowledge of the stated risks, Parent/Legal Guardian represents and warrants to the "Releases" that the Child is in good physical health and that except for his/her visual and/or other impairments that may exist, does not have any physical condition which will interfere with his/her ability to participate in the BCLC programs, or endanger his/her health in connection with such programs.

ASSUMPTION OF RISK:

The Parent represents that the Child is voluntarily participating in the BCLC programs and treatment at the BCLC. THE PARENT/LEGAL GUARDIAN ON BEHALF OF THE CHILD, VOLUNTARILY ASSUMES ALL RISK OF "LOSS", AS DEFINED HEREIN. The Parent/Legal Guardian does hereby releases and discharge each and every one of the "Releases" of any responsibility for and shall indemnify each of the "Releases" against and hold them harmless from, any and all "Loss" suffered or incurred by the Child which arise out of, or are in anyway connected with the BCLC programs, the activities, in diagnosis, or treatment of the Child by BCLC or its employees or services. The Parent/Legal Guardian, on his/her own behalf and on behalf of the Child, hereby agree not to sue or bring suit or legal or equitable action against any of the "Releases" of the matters covered by the foregoing releases and indemnities.

SUCCESSORS AND ASSIGNS:

The releases and covenants given herein shall be binding upon the Parent/Legal Guardian and Child, and the Child's heirs, assigns, and personal representative. If any of the provisions or any portion thereof of this HOLD HARMLESS AGREEMENT shall be held invalid or inoperative, the remaining provisions, or portions thereof, shall nevertheless be given full effect. This Hold Harmless Agreement cannot be modified or terminated orally by the Parent/Legal Guardian of the Child.

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I have read and understand fully, all elements of this HOLD HARMLESS AGREEMENT. I further understand fully that this HOLD HARMLESS AGREEMENT is legally binding in all terms presented herein. As Parent/Legal Guardian of the named Child and on behalf of the Child, wish to voluntarily participate in the BCLC Programs. I represent to you that I am legally authorized to sign this AGREEMENT for the herein named Child.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE: \_\_\_\_\_



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**Early Childhood Center**

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Acknowledgement of Receipt of Child Abuse Prevention Pamphlet

This will acknowledge that I/we, the parent(s)/legal guardian of:

CHILD'S NAME (PLEASE PRINT): \_\_\_\_\_

Have received a copy of "Facing the Facts", as Parent's Guide to understanding of Child Sexual Abuse (Pamphlet.), from the Blind Children's Learning Center.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE: \_\_\_\_\_



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Early Childhood Center**

Grievance Process/Procedure Acknowledgement

CHILD' NAME: (PleasePrint) \_\_\_\_\_

You, as the parent/legal guardian of a child enrolled in the Blind Children's Learning Center's (BCLC) Infant/Pre-school programs, are encouraged to talk with your Child's teacher concerning any problem(s), complaint(s), or suggestion(s) that you may have.

There are a series of **POLICIES** written and published by the President/Executive Director of BCLC, for the specific protection and education of your Child. Every staff member of BCLC is obligated to encourage all parents/legal guardians of an enrolled Child to **communicate** with them, directly, about anything concerning their Child.

BCLC ask that you respect and abide by our **GRIEVANCE PROCESS/PROCEDURE** by first talking to the person, directly, with whom you have a grievance. If this is not possible or if you are dissatisfied with the proposed resolution, then secondly, talk with that persons' direct line management. If again you are dissatisfied, with the proposed resolution, then thirdly, feel free to take the matter to Executive Management. If, in the parents' opinion, the situation remains unresolved, the problem or suggestion can be further addressed in writing or by using the **BCLC GRIEVANCE FORM** which can be obtained through any level of BCLC management.

BCLC request that you handle your **GRIEVANCE** with discretion. Do not talk or discuss the matter with anyone other than the involved person(s) or members of management you have chosen to involve. This discretion protects you from being misquoted, protects your privacy, and allows BCLC to appropriately, without outside influence, resolve the problem or address your suggestion.

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I hereby **ACKNOWLEDGE** that I have read and understand the **GRIEVANCE PROCESS/PROCEDURE** as presented above, and represent to you that I, as parent/legal guardian, am legally authorized to sign this **ACKNOWLEDGMENT** for the above named Child.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE: \_\_\_\_\_

**BLIND CHILDREN'S LEARNING CENTER**  
**POLICY - DRUG AND ALCOHOL-FREE WORKPLACE**

**POLICY NO. B-V**

This Policy is written to ensure the safety of Blind Children's Learning Center (BCLC) enrolled children, employees, interns/volunteers, visitors, services, and property. This is accomplished, in part, by employing a ZERO TOLERANCE attitude for drugs and alcohol anywhere on BCLC property. This Policy strictly prohibits the use, possession, distribution or selling of alcohol or any legal/illegal drugs on BCLC property, or reporting to work under or at any time being under the influence of alcohol or any illegal substance while on duty. "Under the Influence" means the presence of any measurable amount of alcohol or illegal drugs.

If anyone has a reasonable suspicion that an employee, parent/legal guardian, intern/volunteer or any contracted service has violated this Policy, they are obligated to report their suspicion to BCLC Executive Management who will then conduct an investigation, which may include an unannounced search of the BCLC premises or property and/or the involved person's personal property. BCLC may also order anyone reasonably suspected of having used or being under the influence of alcohol or illegal drugs, while on BCLC property, to take a test to determine the presence of drugs or alcohol. An independent laboratory, at BCLC's expense, will conduct such a test. Any employee, intern/volunteer, or contracted service asked to undergo a test will be suspended from work and prohibited from entering BCLC property, until further notice.

BCLC maintains a referral service for employees with substance abuse problems. Any employee with a substance abuse problem will be expected to maintain the same standards of conduct as all other employees, but will not be retaliated against or disciplined for admitting the problem, if the employee is actively seeking assistance. BCLC may also provide unpaid time off for an employee to attend an appropriate rehabilitation program.

Every employee, intern/volunteer, contracted service and parent/legal guardian must acknowledge receipt of this Policy and agree, as a condition of employment, internship/volunteering, and contracted service to:

- Abide by the terms of this Policy, and
- Notify BCLC of any criminal drug conviction(s) for a violation occurring in the workplace not more than five (5) days after such conviction.

**BLIND CHILDREN'S LEARNING CENTER**  
**POLICY - ZERO TOLERANCE FOR WEAPONS**

**POLICY NO. B-VI**

This Policy is written to ensure the safety of the Blind Children's Learning Center (BCLC) children, parents, employees, volunteers, visitors, and property, in part, by employing an absolute ZERO TOLERANCE for weapons or inherently dangerous items of any kind on the BCLC's premises/grounds. The following are considered deadly weapons, but are not necessarily the only items considered as deadly weapons:

.firearms	.knives (over 2"blade)	.explosives (including fireworks)	
.realistic guns	.nun-chukas	.ninja knives	.blackjacks
.metal "brass" knuckles		.large chains	.small chains

Other items, having no reasonable use to the BCLC children, parents, employees, volunteers, visitors, or property, can be considered dangerous or potentially dangerous if used inappropriately to injure others or instill fear at BCLC or BCLC activity. For example, a piece of glass on the ground is not a weapon, per say, but is picked up and used or possessed with intent to provoke fear, it becomes a weapon.

Any child, parent, employee, intern/volunteer, contracted service or visitor found in violation of this Policy will be dismissed/removed from BCLC 's property and, if necessary, appropriate action with Law Enforcement Authority will be initiated by the highest level of management in charge on the day of the incident.

Every employee, intern/volunteer, service, and parent/legal guardian must acknowledge receipt of this Policy and agree, as a condition of employment, child enrollment, internship/volunteer, or contracted service to:

Abide by the terms of this Policy, and Notify BCLC of any criminal weapons conviction(s) for a violation occurring in the workplacenot more than five (5) days after such conviction.

**BLIND CHILDREN'S LEARNING CENTER  
POLICY - NON-SMOKING ENVIRONMENT**

POLICY NO. B-VII

This Policy is implemented as another element of ensuring the healthiest environment possible for our employees, interns/volunteers, contracted services and above all, children, that work/attend the Blind Children's Learning Center (BCLC). This Policy also implements City Regulations for a non-smoking working environment. Smoking is not permitted anywhere on BCLC property. This includes sitting in a car and smoking while the car is on BCLC property.

All employees, interns/volunteers, visitors, services, and parent/legal guardian when on BCLC property are **required** to abide by this Policy. **Failure to comply with this Policy by an employee will result in termination.** Failure to comply with this Policy by an intern/ volunteer, visitor, service, or parent/legal guardian will result in a reminder, initially. If that person persists in smoking on BCLC property, they will be asked to not return to BCLC property. **There are no exceptions to this Policy.**

Every employee, intern/volunteer, contracted service, and parent/legal guardian are required to acknowledge receipt of this Policy and agree, as a condition of employment, internship/ volunteering, service, or being present on BCLC property, to abide by the conditions of this Policy.

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I have read and understand BCLC's Non-Smoking Environment Policy and agree to abide by the conditions of the Policy. I understand that any violation of this Policy may result in serious disciplinary action, up to and including immediate termination of employment, internship/volunteerism, contracted service, or BCLC Programs.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I have read and understand BCLC's Drug and Alcohol-Free Work Place Policy and agree to abide by the conditions of the Policy. I understand that any violation of this Policy may result in serious disciplinary action, up to and including immediate termination of employment, internship/volunteerism, contracted service, or BCLC Programs.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I have read and understand BCLC's Zero Tolerance for Weapons Policy and agree to abide by the conditions of the Policy. I understand that any violation of this Policy may result in serious disciplinary action, up to and including immediate termination of employment, internship/volunteerism, contracted service, or BCLC Programs.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

\_\_\_\_\_, born \_\_\_\_\_ is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m., \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_

Vision: \_\_\_\_\_ Insect stings: \_\_\_\_\_

Developmental: \_\_\_\_\_ Food: \_\_\_\_\_

Language/Speech: \_\_\_\_\_ Asthma: \_\_\_\_\_

Dental: \_\_\_\_\_

Other (include behavioral concerns): \_\_\_\_\_

Comments/Explanations: \_\_\_\_\_

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: \_\_\_\_\_

### IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY (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



# CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

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

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

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<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
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## 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: \_\_\_\_\_ Community Care Licensing Division \_\_\_\_\_  
 750 The City Drive, Suite 250  
 Licensing Office Address: \_\_\_\_\_ Orange, CA. 92868 \_\_\_\_\_  
 Licensing Office Telephone #: \_\_\_\_\_ 714-703-2800 \_\_\_\_\_

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](http://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](http://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 Division		
	750 The City Drive, Suite 250		
ADDRESS	Orange, CA. 92868		
	714-703-2800		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER	

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)



Bright Visions  
Early Childhood Center

Parent/ Legal Guardian Survey

WE CAN PROVIDE BETTER SERVICE TO YOUR CHILD BY KNOWING SOMETHING ABOUT YOU,  
THE PAREN/LEGAL GUARDIAN. WE ACCOMPLISH THIS, IN PART, THROUGH THIS SURVEY.  
PLEASE CHECK THE RESPONSE THAT APPLIES FOR EACH QUESTION LISTED BELOW:

=====

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

1. What is your relationship to the child?

Father     Mother     Grandfather     Grandmother     Legal Guardian

2. Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_

3. Which California County do you live in? \_\_\_\_\_ City \_\_\_\_\_

4. How many times have you moved in the last 24 months? \_\_\_\_\_

5. Homeownership: Rent \_\_\_\_\_ Own \_\_\_\_\_

6. What is your age category?

Under 20     40 - 49  
 21 - 29     50 - 59  
 30 - 39     above 60

6.1 What is the annual household income range before taxes?

Below 10,000     41,000 - 59,000  
 10,000 - 29,999     60,000 - 79,999  
 30,000 - 40,000     above 80,000

7. What is your highest level of education?

Elementary 0 - 5     1 - 2 yrs. of college  
 6 - 8 grade     3 yrs. of college or more  
 9 - 12 grade     Graduate School

7.1 What is your spouse's highest level of education?

Elementary 0 - 5     1 - 2 yrs. of college  
 6 - 8 grade     3 yrs of college or more  
 9 - 12 grade     Graduate School

8. What is your current occupation? \_\_\_\_\_

8.1 What is your spouse's current occupation? \_\_\_\_\_

9. What is your ethnicity?

African American  
 American Indian, Eskimo, Aleut  
 Asian American  
 Pacific Islander

Hispanic  
 White, non-Hispanic  
 Other, please specify:  
\_\_\_\_\_

10. What language do you normally speak at home? \_\_\_\_\_ Do you speak English? \_\_\_\_\_

11. Insurance Information?: \_\_\_\_\_