



Mt. Calvary Kid's Corner
Preschool & Child Care Center

LIC#364805430 and LIC#364805431

Student File Enrollment Packet

Child's Name _____

The following forms should be in this packet and all must be filled out completely and returned before your child can attend school

_____ Application for Enrollment

_____ Admission Agreement

_____ Participation in School Activities Waiver

_____ Parent Handbook Acknowledgement/Illness Checklist

_____ Emergency Card

_____ Photo Release

_____ My Child Form

_____ Identification & Emergency Information (LIC700)

_____ Preadmission Health History-Parent's Report (LIC702)

_____ Personal Rights (LIC613A)

_____ Parent's Rights (LIC995)

_____ Consent for Medical Treatment (LIC627)

_____ Physician's Report (LIC701) (Not applicable for school age)

_____ Immunization Record (Not applicable for school age)

_____ Immunization Record (Blue Card) (Not applicable for school age)



Mt. Calvary Lutheran Kid's Corner

APPLICATION FOR ENROLLMENT 2023-2024

Child's Name _____
(first) (middle) (last)

Child's Birthdate _____ Start Date _____

Parent's Names _____

Mailing Address _____
(P.O. Box) (City) (Zip Code)

Emails _____

Mom's #'s Home _____ Cell _____ Work _____

Dad's #'s Home _____ Cell _____ Work _____

Please check the program times/days you wish to enroll your child:

_____ 8:30 – 12:30 Preschool Program

_____ 8:30 - 2:30 Extended Day

_____ Full Day (7:00am-6:00pm)

_____ School-Age Before & After School Grade (School Age only) _____

Days (circle days needed) Monday Tuesday Wednesday Thursday Friday

**** You must pay the registration fee to reserve placement for your child.****

This registration fee is Non-refundable.



Mt. Calvary Kid's Corner
Preschool & Child Care Center
Admissions Agreement

LIC#364805430 and LIC#364805431

Mt. Calvary Kid's Corner Preschool & Child Care Center offers a preschool program, extended care program and before & after school program. We offer three preschool classrooms, a 2 year old class (Tadpoles), a 3-year-old class (Sock Monkeys) and a Pre-K class (Busy Bees). Preschool classroom times are 8:30am to 12:30pm and preschool extended hours are 8:30am to 2:30pm. Our extended hours for kindergarten and full day program are from 7:00am to 6:00pm, including additional preschool class time. The school-age program starts at 7:00am before school and 12:00pm to 6:00pm after school.

Parents must agree to comply with the rules and regulations of Mt. Calvary Kid's Corner Preschool & Child Care Center regarding attendance fees, Covid policies, immunizations, and health, as well as other items listed in the Parent's Handbook issued by the school. Parent's must understand the preschool will be closed for the holidays listed in the Parent's Handbook and other days. Parents will be given reminders of holidays in writing but receiving the Parent's Handbook constitutes notice of these days.

Parents must understand there will be no monthly reduction in the monthly tuition when there are such holidays, as vacation and holidays are figured into the payment schedule.

Parents must hereby agree to notify the school two weeks in advance of withdrawal should that event occur. If parents must withdraw a child and are unable to give the required notice and additional two weeks of tuition must be paid.

***Refunds of tuition will be given only if the year's tuition has been paid in full.
Non-refundable registration is \$100 per child or \$150 for a family for the year (due every September).***

Tuition checks are to be made payable to **Mt. Calvary Lutheran Church School**. Tuition payments are due on the 1st of each month. Mt. Calvary Kid's Corner Preschool & Child Care Center also accepts weekly payments for your convenience. The \$100 registration fee is due before the child is officially enrolled. The registration fee and completed paperwork is required to assure placement in Mt. Calvary Kid's Corner Preschool & Child Care Center.

Mt. Calvary Kid's Corner Preschool & Child Care Center will give at least 30 calendar days' notice before changing its rates and fees.

Parents must understand that the State of California licensing agency has the right to inspect the files in the school including their child's file and can also talk with their child and check their physical wellbeing. Their child may also have other rights as listed in title 22, Division 12 Section 101195(b) and (c).

I have read this one-page agreement and agree to the terms it states, including I agree to give the school at least two week notice if it should become necessary to leave before the end of the school year.

Signature of Mother/Date

Signature of Father/Date

Signature of Legal Guardian/Date

Signature of Legal Guardian/Date



Mt. Calvary Kid's Corner
Preschool & Child Care Center
Participation in School Activities

LIC#364805430 and LIC#364805431

I hereby grant permission for my child, _____
to use all of the play equipment and to participate in all of the activities of Mt. Calvary Lutheran Kid's Corner
Preschool & Child Care Center.

I hereby grant permission for my child to leave the school premises under the direct supervision of a staff
member for neighborhood walks, go play at the park and the library. If a field trip in an authorized vehicle or
walking is planned, I understand that I will be notified ahead of time and will be required to sign a permission
slip pertaining to this planned activity. If at any time I do not wish my child to go on a particular trip, I must
notify the director.

I hereby grant permission for my child to be included in evaluations, pictures and videotaping connected with
the school program.

I will bring my child to and pick my child up at the classroom door. I will sign my child in and out each day. Mt.
Calvary Kid's Corner Preschool and Child Care Center will not be held responsible for situations arising because
of false information given at the time of enrollment.

Parent/Guardian Signature

Date

I request my child NOT participate in the following activities: _____



Mt. Calvary Kid's Corner

Preschool & Child Care Center

Parent Handbook Acknowledgement

LIC#364805430 and LIC#364805431

I have read and understand the Parent Handbook, including the sick child policies and the days that Kid's Corner will be closed. **I agree to the policies as stated herein.**

Signature of Parent/Guardian

Date

Your Child's Health

Your child's health is important to us. Your child will be sent home if he or she appears to have symptoms of illness during the school day. If the parent cannot be reached, we will call one of the emergency references to pick up the child.

As stated in the Parent Handbook, *please*:

Keep your child at home if he or she:

- ☐ Has a fever or has had one during the previous 24 hours.
- ☐ Just came down with a cold and is sneezing
- ☐ Has a yellowish or greenish nasal discharge
- ☐ Have symptoms of a possible communicable disease. (These are usually sniffles, reddened eyes, sore throat, headache, abdominal pain, fever, rash or spots.)
- ☐ Has diarrhea/had diarrhea or vomiting in the past 24 hours.
- ☐ Has a rash or spots.
- ☐ Head Lice – Child must be free of active lice and nits (eggs)

Your child may come to school if:

- ☐ Children must be fever free, vomiting free and/or diarrhea free for 24 hours
- ☐ Their cold is over, but minor, clear nasal drip remains
- ☐ Exposed to a communicable disease, and the school was notified, and the appropriate Incubation period has been satisfied, or doctor's release is presented.

Signed _____

Date _____

EMERGENCY CARD

Full Name of Child			Birth date		
P.O. Box	City	Zip	Street Address		
Mother or Guardian	Home Phone #	Business Phone #	Cell Phone #		
Father or Guardian	Home Phone #	Business Phone #	Cell Phone #		
Name of Local Doctor		Office Address	Office Phone		

Allergies?—Please list _____

May we contact any available physician? YES _____ NO _____

Last tetanus toxoid booster was given on _____

Insurance Company _____ Policy #/Group # _____

What health problems does the child have? _____

PERSONS AUTHORIZED TO PICK UP CHILD:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IN THE EVENT THAT PARENTS CANNOT BE REACHED, PLEASE CONTACT:

1. _____
Name Phone Number
2. _____
Name Phone Number

In the event our child _____ becomes ill or sustains an injury while in the care or under the supervision of Mt. Calvary Kid's Corner Preschool and Child Care Center, any of its employed staff are given permission to administer first aid for his/her relief. If it is not practical to return him/her to us or to or to receive our instructions for his/her care, *consent is hereby given to any licensed physician and/or surgeon called*, or to whom our child is taken for treatment by them to administer such treatment, drugs and medicines, and to perform such surgical procedures as the physician shall think the existing emergency requires for the relief of pain and preserve his/her life and health. Authorization is also given for such other measures or procedures as may be required. I agree to pay all expenses and costs associated with such care and related transportation.

Signed: _____
Parent or Guardian Phone Number Date



Mt. Calvary Kid's Corner
Preschool & Child Care Center
Photo Release

LIC#364805430 and LIC#364805431

Child's full name: _____

Photographs are taken on different occasions such as birthdays, holidays, outings and special occasions, as well as everyday activities. We use these pictures in our preschool for teaching, arts & crafts, albums and various other things. Please mark the appropriate boxes

Mt. Calvary Lutheran Kid's Corner may take photographs of my child:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo for art projects to be display on the walls:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo on their Social Media pages:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo on Class Dojo or ProCare:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo on the school website:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo for marketing and advertising purposes:

☐ I give permission ☐ I do NOT give permission

Mt. Calvary Lutheran Kid's Corner may use my child's photo in the school yearbook:

☐ I give permission ☐ I do NOT give permission

Parent/Guardian Signature _____ Date _____



Mt. Calvary Kid's Corner
Preschool & Child Care Center

LIC#364805430 & LIC#364805431

MY CHILD FORM

MY CHILD'S NAME _____ BIRTHDATE _____ MALE ___ FEMALE ___

PARENT'S NAME (FATHER) _____ (MOTHER) _____

2 YEAR OLD _____ 3 YEAR OLD _____ PRE-K _____ KINDER _____ SCHOOL AGE _____

WHAT IS THE MOST EFFECTIVE TYPE OF DISCIPLINE FOR YOUR CHILD? _____

WHAT ARE HIS/HER FAVORITE TOYS AND ACTIVITIES AT HOME? _____

DOES HE/SHE LIKE TO BE READ TO? _____

DOES HE/SHE LIKE TO PLAY OUTDOORS? _____

CIRCLE THE ART MATERIALS YOUR CHILD ENJOYS

CLAY CRAYONS GLUE PAINT PLAYDOUGH SCISSORS

DOES HE/SHE HAVE ANY DIFFICULTIES IN SPEAKING? _____

HOW DOES HE OR SHE RELATE TO STRANGERS? _____

WHAT MAKES HIM/HER MAD OR UPSET? _____

IS THERE ANY OTHER INFORMATION YOU THINK THE TEACHER SHOULD KNOW? (THIS IS AN **IMPORTANT** QUESTION,
PLEASE TAKE THE TIME TO THINK ABOUT THIS) _____

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
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PERSON RESPONSIBLE FOR CHILD	LAST	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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

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

DATE OF ADMISSION

LAST DATE OF ENROLLMENT

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE 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* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
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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

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 / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH			

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:
PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY			

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

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

ADDRESS

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)

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

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

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

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

()

WORK PHONE

()

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.