



Enrollment Application

Please fill out this form completely. Use one form per child.

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Current Age: \_\_\_\_\_ Gender (circle one) M F

Parent/Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Best Email: \_\_\_\_\_

Schedule:

Circle your preference for days of attendance:

Monday          Tuesday          Wednesday          Thursday          Friday

Circle your preference for times of attendance:

7am – 6pm          8:30am – 3pm          8:30am – 11:30          1:30pm – 4:30pm  
full day          core day          morning half day          afternoon half day

How did you find out about Achieving Stars Academy?

Please check the option that most closely represents your first introduction to the school.

- \_\_\_\_\_ Internet search/website
- \_\_\_\_\_ The Little Gym
- \_\_\_\_\_ Sign on Building
- \_\_\_\_\_ Friend/Colleague
- \_\_\_\_\_ Other \_\_\_\_\_

301 South Abbott Avenue  
Milpitas, CA 95035  
(408) 263-8802  
(408) 263-8844 fax  
michelle@achievingstars.com

# 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)

# 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  
( )

# 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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# 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/DaP/ 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

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**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.

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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:**

	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 LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ 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*
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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

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### 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](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### 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)*

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ADDENDUM TO PARENT AGREEMENT, COVID-19 - June 1, 2020

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The reopening of Achieving Stars Academy has been guided by the following principles: protect the health and safety of students and staff, follow the guidelines set out by local, county, and state governments. These procedures come from State Shelter in Order, Centers for Disease Control, Public Health, Social Services & Licensing.

Start and End Times – The start and end times have been modified to allow for social distancing and additional cleaning procedures for the school.

**Full Day – 8:15am – 5:00pm**

**Core Day – 8:40 -2:30pm**

**Half Day – 9:00am – 12:00noon**

Tuition was increased by 10% to pay for the cost of additional personnel required to clean the school throughout the day, additional cleaning supplies, and additional teachers required to maintain a lower ratio in each class.

**Full day \$1353.00**

**Core Day \$1078.00**

**Half Day \$836.00**

**Staggered Drop Off Times**

To allow for social distancing, families need to drop off during these times:

**Half Day – Please arrive between 9:00am – 9:15am.**

**Core Day – Please arrive between 8:40am – 8:55am.**

**Full Day – Please arrive between 8:15am – 8:35am.**

The door will be locked at 9:30am. Parents arriving after 9:30am should call the office so a teacher or director can check them in.

**Staggered Pick Up Times**

**Half Day – 11:50am – 12:00pm**

**Core Day – 2:15pm – 2:30pm**

### **Full Day – 4:50pm – 5:00pm**

If you arrive outside of your expected pick up time, please call the school so a teacher or director can bring your child to you.

**Wearing of masks** – staff members, parents and students should wear face coverings when arriving to the facility. Cloth face coverings should be cleaned daily. Parents should teach their child how to put on and take off before reopening the school. The child will not wear during eating and nap. The child will not wear masks during recess breaks if they maintain social distancing.

**Screen/Health Checks upon arriving** – before leaving home, check your child’s temperature. If your child has a temperature of 100.4 degrees and above, your child must stay home. If your child has any signs of illness, your child should stay home. When you arrive at school, your child’s temperature will be taken. Your child’s temperature will be taken at different times during the day.

**Class Configuration** – To minimize contact, the CDC recommends the students remain with the same teacher, classmates, and classroom. For this reason, the student’s schedule will determine their class placement. To ensure all students are being challenged, the teachers will create small groups and differentiate their instruction to meet the needs of every student.

**Food and Water** – Water bottles cannot be brought to school. ASA will provide water frequently throughout the day in single use disposable cups. ASA will no longer heat food in the microwave. Parents should purchase thermoses for hot food. Parents should also provide utensils. ASA will provide snacks. School Caterers Hot Lunch Service will not be used at this time due to time constraints and additional cleaning needed. All Full and Core day students should bring a lunch from home.

**Communications with Parents and Staff** – we will keep parents informed with the progress during this COVID-19, as needs arise. Parents should call the office if they have any questions or need to communicate with a director or teacher.

**Care and Resources for Staff & Parents** – Emails and phone numbers, as well as back up numbers must be kept up to date so ASA can be in contact you immediately if necessary. Reports and correspondence must be read and answered on a timely basis.

**Closing and Reopening during COVID-19** – Should the school get notice that a person who tested positive for COVID-19 was inside the school, you will be immediately notified. ASA will make the appropriate notifications to Public Health.

As an extra precaution, we will be adding the following safety measures:

**Emergency List/Contacts** emails, text numbers will be kept up to date. If your info changes, you are to contact the front desk within a day of the change.

**Temperature checks** during the Day. Besides a temperature check as the child enters school, checks will take place several times during the day. Any temperature at 99 degrees or higher will warrant a call for the parent to come to pick up the child from school immediately.

**Protocol for person** who meets a person diagnosed with COVID-19. You will be expected to contact the office immediately and not bring your child back to the center for a minimum of 18 days. Public Health and Social Services/Licensing will also be contacted.

We will have a list of resources for you if you will need guidance and information. From time to time, we will be sending via email to parents and guardians to update you on the school's health report and information of use to parents re: COVID-19.

**Health Consultant** – ASA has a nurse and doctor on board to advise and recommend changes and procedures that would benefit the safety and care of your child at Achieving Stars.

**Family Days/Field Trips.** During COVID-19, there will be NO Family Days or field trips scheduled through at this time due to the nature of the pandemic. We will not have SHARE DAYS. Sport groups will be looked at with the coaches if they can afford a plan to keep children separated.

This agreement indicates our plans as of today but we may be required to be amend it in the future.

At this time the Santa Clara County Executive Order allows us to accept children of parents who are required to return to work. By signing the addendum, you are indicating the need to return to the workplace.

Signing this document is your agreement that you have read and agree with the safety measures put into place for us to accept your child. Any infraction will mean immediate termination of your placement and enrollment of your child at Achieving Stars Academy.

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

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_