2015-2016 FORMS

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Form #1

2015-2016 Daycare

To purchase daycare hours, please fill out the form below with your payment and return it to the Financial Office or go online: www.sdfrenchschool.org/enrichment/daycare.

Parent's Name: _____

Email Address: _____

Student #1: _____**Student #2:** _____**Student #3:**_____

Cell phone: _____ **Day phone:** _____ **Date:**_____

Method of Payment:

Total Payment: _____ Check #: _____ Cash: _____

Card number:

AMEX - MASTER CARD - VISA (Please circle) Expiration Date: _____/_____

Save this credit card for future purchase: YES NO

Select:

Daycare hours	Child Name	Total
25h		
50h		
100h		
Daycare Package		

Total: $_____

Rates:

Daycare Hours	Rate/hour/child	Total per child
25h	$6.50	$162.50
50h	$6	$300
100h	$5.50	$550
Drop-in no hours on file	$10	$10
$1/minute after 6 pm	$1/minute	$1/minute
Daycare Package (Sept-June)*	$1700 (1st child)	$1500 (2nd child)

*Unlimited use of daycare per child from 7:30-8:00 a.m., 3:00-6:00 p.m. and from 12-6 pm on minimum day from Sept.1, 2015 - June 16, 2016. This package doesn't include the vacation breaks or summer camp.

Form #2

Health and Medication Administration Form

The California Education Code states that any student who is required to take medication (prescription or over the counter) prescribed by a physician during the regular school day, may be assisted by a designated school personnel if the school receives:

1. A written statement from the physician detailing the method, amount and time schedules that the medication is to be taken and
2. A written statement from the student's parent/guardian authorizing the school to administer the medication. (E.C. 49422, 49423)
   (see forms attached)

Please send all medications (prescription and over-the-counter) in a Ziploc bag labeled with your child's name. Medications must be in the original pharmacy container with the original prescription label adhered to the container. Students may carry and self-administer prescription auto-injectable epinephrine and asthma inhalers if so prescribed by the physician.

No other prescription or over-the-counter medications, vitamins, herbs, or alternative medications may be carried by students on their person, in a backpack or other container except as indicated above. **No medications (including over-the-counter) are given at school without a medication statement written by the physician detailing how to give the medication** (see page 2). ***Notification is required to SDFAS when new medications are started at any time during the school year.***

The school has no way of providing for children who are ill except to *contact the parent or emergency contact and request they be picked up and taken home*. For this reason, it is critical that the school have current parent/guardian contact information on file.

For the well being of all students, children should remain at home if they are ill. Below are general guidelines to help you decide if you should keep your child home from school:

Keep at Home	Send to School	See a Doctor
Fever above 100 degrees	Ear infection, no pain	Undiagnosed skin rash
Vomits more than once	Infrequent diarrhea	Eye infection
Flu: body aches, headache, and fever	Minor cold (runny nose, cough, sneezing sore throat)	
	Cold sores (sore covered)	
	Infestation of lice (after treatment begins)	
	Strep throat (after 24 hours of medication)	
	Vague "I don't feel good symptoms"	

Please notify the school office if your child is staying home due to illness

Student Name:_____ **Date of Birth:**_____ **Grade:** _____

Health and Medication Administration Form

This form is to be filled out for any and all medications given to this student while under the supervision of SDFAS. This includes, but is not limited to prescription medications, scheduled medications, **over-the-counter medications** (Tylenol, Benadryl, etc.), emergency medications, etc.

----------***To be filled out by Physician***----------

Must be a California authorized health care provider

1. MEDICATION: _____ **Dose:** _____ **Reason/Dx:** _____
Route: _____ **Start/Stop date:** _____
If daily, times to be given: _____
Other instructions (signs/symptoms for usage, special storage, adverse reaction, OTC instructions, indications): _____
_____
Indications for referral for medical evaluation: _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Dx:** _____
Route: _____ **Start/Stop date:** _____
If daily, times to be given: _____
Other instructions (signs/symptoms for usage, special storage, adverse reaction, OTC instructions, indications): _____
_____
Indications for referral for medical evaluation: _____

3. MEDICATION: _____ **Dose:** _____ **Reason/Dx:** _____
Route: _____ **Start/Stop date:** _____
If daily, times to be given: _____
Other instructions (signs/symptoms for usage, special storage, adverse reaction, OTC instructions, indications): _____
_____
Indications for referral for medical evaluation: _____

NAME OF PROVIDER: _____

ADDRESS: _____

TELEPHONE: _____

SIGNATURE OF PROVIDER: _____

STAMP OF PROVIDER:

Health and Medication Administration Form

Student Name:_____ **Date of Birth:**_____ **Grade:** _____

----------***To be filled out by Parent/Guardian***----------

I/we hereby request that the staff of San Diego French American School assist with giving medication(s) to my/our child _____(student's name) as stated in the above physician instructions. I/we also give permission to contact the physician for consultation and exchange of information as needed.

Release of Liability and Agreement to Indemnify and Hold School Harmless:
I/we hereby expressly release, hold harmless and agree to indemnify and defend San Diego French-American School and its entire staff from all claims and liability for any personal injuries, death, or property damage that may be incurred by permitting the school to assist in giving my child's medication. This release, hold harmless and indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledged in writing by the school principal. I/we understand and agree that if I/we terminate this agreement, the school will no longer assist in giving medication to my child.

I/we understand that school regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school, and not carried on the person of a student. (*Some emergency medications may be self-carried with written physician instructions and compliance with school policies. Must be authorized by physician.)*

Parent/Guardian names:	**Signatures:**	**Daytime phone numbers:**
#1 _____	_____	_____
#2 _____	_____	_____

Other Emergency Contact name: _____ **Daytime phone number:**_____
Relationship to Child: _____

Date: _____

Please return page 2 and 3 to the school

Form #3

Currently, all students who have not received all California state required immunizations need to have an exemption form signed by an authorized healthcare professional licensed in California. Please see form below. Proof of immunization and vaccines must be on file by the first day of the school year.

The new vaccination bill, SB 277 takes effect January 1, 2016, but its provisions will not be implemented until July 1, 2016. When that law goes into effect, a child will not be allowed to attend school if these records are not on file. Further information on this bill is available in the office.

State of California—Health and Human Services Agency

California Department of Public Health

PERSONAL BELIEFS EXEMPTION TO REQUIRED IMMUNIZATIONS

STUDENT NAME (LAST, FIRST, MIDDLE)	GENDER ☐M ☐F	BIRTHDATE MONTH DAY YEAR __ __ / __ __ / __ __ __ __	TELEPHONE NUMBER
PARENT/GUARDIAN – NAME		ADDRESS	

A. AUTHORIZED HEALTH CARE PRACTITIONER LICENSED IN CALIFORNIA – FILL OUT THIS SECTION

I am a (check one): ☐ M.D./D.O. ☐ Nurse Practitioner ☐ Physician Assistant ☐ Naturopathic Doctor ☐ Credentialed School Nurse

Provision of information: I have provided the parent or guardian of the student named above, the adult who has assumed responsibility for the care and custody of the student, or the student if an emancipated minor, with information regarding 1) the benefits and risks of immunization and 2) the health risks to the student and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

_____
Signature of authorized health care practitioner

_____
Date - within 6 months before entry to child care or school

Practitioner name, address, telephone number:

B. PARENT OR GUARDIAN – FILL OUT THESE SECTIONS

I. Check one of the boxes below:

☐ **Receipt of information:** I have received information provided by an authorized health care practitioner regarding 1) the benefits and risks of immunization and 2) the health risks to the student named above and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

☐ **Religious beliefs**: I am a member of a religion which prohibits me from seeking medical advice or treatment from authorized health care practitioners. (Signature of a health care practitioner not required in Part A.)

_____ _____
Signature of parent or guardian **Date - within 6 months before entry to child care or school**

II. AFFIDAVIT

Immunizations already received: I have provided the child care or school with a record of all immunizations the student has received that are required for admission (California Health and Safety Code §120365).

Immunizations for which exemption is requested: An unimmunized student and the student's contacts at school and home are at greater risk of becoming ill with a vaccine-preventable disease. I understand that an unimmunized student may be excluded from attending school or child care during an outbreak of, or after exposure to, any of these diseases for the protection of the student and others (17 CCR §6060). I hereby request exemption of the student named above from the required immunizations checked below because such immunization is contrary to my beliefs.

School Category	Table of Required Immunizations – Check box(es) to request exemption.
Child Care Only	☐ ***Haemophilus influenzae* type b** (Hib meningitis)
Child Care and K-12th Grade	☐ **DTaP** (Diphtheria, Tetanus, Pertussis [whooping cough]) ☐ **Hepatitis B** ☐ **MMR** (Measles, Mumps, Rubella) ☐ **Polio** ☐ **Varicella** (Chickenpox)
7th Grade Advancement (or admission at 7-12th Grade)	☐ **Tdap** (Tetanus, reduced Diphtheria, Pertussis [whooping cough])

_____ _____
Signature of parent or guardian **Date**

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department's information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.

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