

Bright Horizons® Informed Consent

Child's Name: _____

ACCESS

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

CHILD RELEASE

For a child's safety, Bright Horizons will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order.

Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.
- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.
- If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**. (Note: In RI, parents/guardians must also provide notice in person and in writing.)
- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

NAME

ADDRESS

CITY/TOWN/STATE/ZIP

RELATIONSHIP TO CHILD

DAYTIME PHONE

CELL PHONE

E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY?

☐ YES

☐ NO

NAME

ADDRESS

CITY/TOWN/STATE/ZIP

RELATIONSHIP TO CHILD

DAYTIME PHONE

CELL PHONE

E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY?

☐ YES

☐ NO

NAME

ADDRESS

CITY/TOWN/STATE/ZIP

RELATIONSHIP TO CHILD

DAYTIME PHONE

CELL PHONE

E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY?

☐ YES

☐ NO

Bright Horizons will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

WALK PERMISSION

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises.

- ☐ I give permission for my child to participate in walks.

Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

PARENT/GUARDIAN INITIALS: _____

PHOTOGRAPHY & VIDEO PERMISSION

Bright Horizons regularly takes photographs and videos of children enrolled for its business purposes. Bright Horizons retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. They may be shared with you and other families on a Bright Horizons' website, by e-mail, by posting in the center, or in a parent newsletter. They may be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. They may be used for other center, general business, and marketing purposes, including online. Bright Horizons takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner.

- ☐ I give permission for Bright Horizons to take photographs and videos of my child and use these materials for its business purposes.

CHILD ILLNESS

If my child becomes ill, I will be called. I may be required to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Family Guide contains Bright Horizons' full Child Illness Policy, including protocols for contagious illnesses.

FAMILY GUIDE ACKNOWLEDGEMENT

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Bright Horizons Family Guide or client equivalent, as well as any center-specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE



Annual parent/guardian review and signature is required by Bright Horizons and some state licensing agencies. If any changes are necessary, a new form will be completed.

PARENT/GUARDIAN SIGNATURE

REVIEW DATE

PARENT/GUARDIAN SIGNATURE

REVIEW DATE

PARENT/GUARDIAN SIGNATURE

REVIEW DATE

CHILDREN'S INJURIES

If my child sustains a minor injury during care, I will receive an Occurrence Report when I pick-up describing the incident. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

EMERGENCY MEDICAL CARE

If emergency medical attention is needed for my child, _____, the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Bright Horizons to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to _____ my preferred facility, if possible.

Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

CHILD'S HEALTH INSURANCE PROVIDER

NAME OF INSURED

POLICY NUMBER

BRIGHT HORIZONS ENROLLMENT AGREEMENT

Welcome to Bright Horizons! We look forward to a healthy and happy relationship with your family. The following policies were created to promote the smooth operation and safety of the program while providing care for the children.

TUITION AND FEES

1. Please specify the days and hours your child, _____ will attend:
Monday: _____ Tuesday: _____ Wednesday: _____
Thursday: _____ Friday: _____
If your hours change in any way, notify Bright Horizons immediately. Tuition rates will be adjusted to reflect any permanent change in hours.
2. You are required to give one month's notice in writing of any reduction in your child's schedule, or in the case of a client center, the notice required by your employer. Tuition will be reduced to the new rate thirty (30) days after notice is received. If your child's schedule changes in any way, Bright Horizons cannot guarantee that a space will be available.
3. Tuition of \$ _____ is due in advance each _____ via online recurring payment, where available, or by payroll deduction if available through your employer. Tuition will not be reduced for any absences, including vacations, illnesses, or holidays. You will be charged for any other hours of care in addition to your child's usual schedule. Bright Horizons reserves the right to change tuition rates and you will be notified of any change at least thirty (30) days prior to its implementation. Tuition is based on ratios in assigned classrooms.
4. Your first tuition payment of \$ _____ will reserve your child's space. If Bright Horizons is unable to provide a space for your child, this payment will be refunded.
5. When you withdraw your child, you must give at least thirty (30) days written notice **prior to withdrawal**, or in the case of a client center, the notice required by your employer. You agree to pay all tuition and fees for the thirty (30) days following your notice to the Center, even if your child is not in attendance.
6. Tuition is paid in advance and is due by:
 - The 25th of the prior month, for monthly payments.
 - The prior Friday, for weekly payments (where applicable).
 - Other: _____ (where applicable).If the full tuition is not received when due, a late fee of \$ _____ per day will be added until the tuition is paid in full. Although payments may be split between parents or supported by a subsidy, each parent is responsible for timely payment of the full tuition. If payment is delinquent for one week or more, care may be suspended until the full balance is current and your child's space will not be reserved. Tuition is due regardless of a child's absence from the program for any reason, and is required to hold a child's space.
7. A non-refundable registration fee of \$ _____ is due at the time of registration, if applicable. A re-registration fee is due annually and subject to change. If your child withdraws from the program and later re-enrolls, a new registration fee is due at that time.
8. A late pick-up fee of \$ _____ per child is payable for each minute your child(ren) remains after closing. This fee is subject to change.
9. A \$25.00 fee will be charged for a check returned for insufficient funds. If this occurs more than once, Bright Horizons may require payment by another method for enrollment to continue.
10. Your child may have the opportunity to participate in a special program or field trip. This may result in an additional fee due before the day of the event. Notices will be posted in advance. A signed permission slip will be required in order for your child to participate in a field trip.
11. If your tuition is subsidized, any misrepresentation of gross household income or subsidy status may result in dismissal from the program and/or retroactive charges for all underpaid tuition.

COMINGS AND GOINGS

1. The Center is open from _____ a.m. to _____ p.m., Monday-Friday. The Center is closed for certain holidays. The Center's hours and holiday schedule are set and posted annually, but may be changed at any time with thirty (30) days' prior notice.
2. The Center will be open whenever possible on a regularly scheduled day, during usual business hours. The procedure for notifying families of closures or late openings due to severe weather or other conditions will be posted. If it is necessary to close early, it will be your responsibility to arrange for your child's early pick up. There will be no tuition credit for any time the Center must close.
3. Your child will only be released to you or to the persons you have listed on the *Informed Consent Form/Child Release*. Emergencies may prevent you from picking up your child; therefore, include those individuals whom you would authorize in such events. If you want a person who is not identified on the *Child Release* to pick up your child, you must notify Center management in advance, in writing. **Your child will not be released without prior written authorization.**
4. Late pick-up is an exceptional occurrence and not a normal program option. It can be distressing for children to be left in the care of others after-hours. Staff work long days and expect to leave at the end of their scheduled times. Please allow enough time to arrive at the Center, pick up your child and leave by closing time. If a child has not been picked up after closing and we have not heard from you, we will attempt to contact you and then the emergency contacts listed on the *Child Release*. Provisions will be made for someone to stay with your child as long as possible, but if we are unable to reach you or an emergency contact after two hours, we will call the local child protective services agency and/or the local police as required by state licensing. Repeated late pick-ups may result in dismissal from the program.
5. Bright Horizons legally cannot deny access to or release of a child to either parent/guardian, unless there is an active restraining order, a specific schedule of court-ordered visitation rights, or other Court Order in place. If the family is not in agreement or the situation is unclear, we will require the family to return to the court to resolve their differences.

MEDICAL POLICIES

1. Prior to enrollment, you must give the Center current medical and immunization records for your child, which must be updated annually. Children without appropriate, current medical records may not attend the Center.
2. If you are notified that your child is ill, you must pick up your child within 90 minutes. If your child is absent due to a reportable disease, your child may return only with a physician's note indicating that he or she is no longer contagious (see the *Child Illness Policy* in the *Bright Horizons Family Guide*).
3. We will administer medication as outlined in our *Medication Policies* (see the *Bright Horizons Family Guide*).
4. In case of emergency, you agree that Bright Horizons has your permission to administer first aid or to obtain emergency medical treatment in the child's best interest (see the *Informed Consent Form/Emergency Medical Care*).
5. Student accident insurance is provided by Bright Horizons. This is a **secondary insurance that will help defray the cost of out-of-pocket medical expenses** which are not covered by a family's primary insurance and **relating to an injury while the child is in the program.**

Original: Child's File

Pink Copy: Parent/Guardian Copy

MISCELLANEOUS

1. In an effort to maintain the professional status of our staff and prevent any potential conflict of interest, babysitting by Center staff is discouraged. However, should you hire any Center staff, it must be outside the Center premises and with the understanding that such arrangement and payment for services are solely between you and the staff member. These arrangements are not sanctioned by the Center, client, or by Bright Horizons, and you agree to hold Bright Horizons harmless from any liability arising from such arrangement. In addition, if a staff member leaves Bright Horizons' employment to work for you within six (6) months of his or her departure; you agree to pay a placement fee of \$5000.
2. It is our expectation that a child can be safe in our group program without dedicated one on one care. If Bright Horizons is concerned that your child's needs are not being met in our group program, we will involve you in the process of identifying the issues and working toward resolution. However, if after reasonable and appropriate interventions have been tried, Bright Horizons determines that your child cannot participate safely in our group program, we may require that your child be suspended until our concerns are adequately addressed. If Bright Horizons believes, in its sole discretion, that the actions of a parent or guardian are disruptive, inappropriate or inconsistent with the Center's best interests, it may elect to end its relationship with the family.

This Enrollment Agreement is not intended to be all inclusive. Other terms and conditions of your child's enrollment are contained in our Family Guide. Your enrollment is also subject to all of Bright Horizons' policies and procedures which may change from time to time. Your tuition is subject to adjustments to reflect changes in your child's schedule and/or classroom as he/she ages up through our program.

I acknowledge that I have received a copy of the *Bright Horizons Family Guide*, which is intended to supplement this Agreement. I understand it is my responsibility to contact Bright Horizons with any questions I have about the information contained in the *Family Guide* or any document relating to enrollment policies and procedures.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Center Director: _____ Date: _____

BRIGHT HORIZONS ENROLLMENT AGREEMENT ADDENDUM

Parents are responsible for understanding and complying with the following safety policies to protect your children and allow for smooth operation of our programs. These policies supplement those reflected in the Enrollment Agreement, the Informed Consent and the Family Guide. **Repeated failure to comply with these policies (either separately or in combination), may result in your family's disenrollment from the Center.**

TUITION AND FEES

Late Pick-up Fees:	\$1.00 per minute per child
Sign-in/out failure fees:	\$25 second failure \$50 third failure \$150 fourth and subsequent failure, plus any fine assessed against the Center

COMINGS AND GOINGS

Late Pick-ups: Children are expected to be picked-up in a timely manner when their program ends, and the late pick-up policy applies for every program. Late pick-up may be excused if there is a common problem or an emergency impacting a group of parents. Late fees are charged at a rate of \$1.00 per minute per child, and are due to the school within 48 hours. Each late pick-up will result in a written notice with the applicable charge, which will be recorded in the school office. The third notice will be considered the final notice, with disenrollment occurring on the 4th event.

Authorized Pick-ups: As fully described in the Informed Consent, E.D.S. can only release a child to those persons identified on the signed Authorized Pick-up list, unless the parent provides advance written notice with parent signature. The written notice may be provided in the parent log or a scanned note attached to an email. Anyone picking up a child must be prepared to provide a photo ID.

Unreported Absences: If a child does not arrive as scheduled, it is cause for alarm and immediate action by staff to locate the child. If parents fail to notify E.D.S. in advance of an absence for any reason (illness, emergency, vacation, play dates, early pick-up from school, etc.), this will result in a written notice. The third notice will be considered the final notice, with disenrollment occurring on the 4th event.

Signing In and Out: Parents or parent-authorized adults are required to sign a child in/out to meet the requirements of our license. Failure to do so may result in administrative action and financial penalties assessed against the School by the California State Department of Social Services. E.D.S. staff will only sign children in or out that are going to or coming directly from the elementary school. If you fail to properly sign your child in or out, the following consequences will apply:

First failure: You or a person on your authorized pick-up list will be called and required to return to the center to sign your child in or out or to pick up your child. If you do not return, disenrollment will result.

Second failure: You will be required to return and fined \$25 payable to the center within 48 hours.

Third failure: You will be required to return and fined \$50 payable to the center within 48 hours.

Subsequent failures: You will be required to return and to pay \$150 per additional incident in addition to any fine assessed against the Center.

This Enrollment Agreement is not intended to be all inclusive. Other terms and conditions of your child's enrollment are contained in our Family Guide. Your enrollment is also subject to all of Bright Horizons' policies and procedures which may change from time to time. Your tuition is subject to adjustments to reflect changes in your child's schedule and/or classroom as he/she ages up through our program.

I acknowledge that I have received a copy of the *Bright Horizons Family Guide*, which is intended to supplement this Agreement. I understand it is my responsibility to contact Bright Horizons with any questions I have about the information contained in the *Family Guide* or any document relating to enrollment policies and procedures.

Child's Name: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

Signature Center Director: _____

Date: _____

For office use only: Record of Policy Notices

Date	Reason & Notes	Notice #

Sunscreen and Insect Repellent - Permission

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosol sprays are prohibited.

Sunscreen/sun block must provide UVB and UVA protection with an **SPF of 15 or higher**. Sunscreen **may not** be used on infants under **6 months** of age unless accompanied by a doctor's note.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less**. Insect repellent **may not** be used on infants under **2 months** of age. Oil of lemon eucalyptus and para-methane products may not be used on children under the age of three.

All sunscreen/sun block and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date;
- appropriate for the age of the child; and
- free of nut ingredients.

I give Bright Horizons permission to apply (name of sunscreen) _____
and/or (name of insect repellent) _____
when outdoor conditions warrant and consistent with package instructions (subject to any special
instructions below) to my child, _____ >

From: ____/____/____ To: ____/____/____ (not to exceed one year)

Special Instructions

Sunscreen/Sun Block: _____

Insect Repellent: _____

(Parent/Guardian Signature)

(Date)

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
---	------

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

DATE OF ADMISSION	DATE LEFT
-------------------	-----------

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

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

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)
BRIGHT HORIZONS/MARIN DAY SCHOOLS. This Child Care Center/School provides a program which extends from 7 : 30
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to 6:30 a.m./p.m., 5 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:

Learning: _____ Allergies: medicine: _____
Vision: _____ Insect stings: _____
Developmental: _____ Food: _____
Language/Speech: _____ Asthma: _____
Mental: _____
Other (Include behavioral concerns): _____
Comments/Explanations: _____

EDUCATION 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)	/ /	/ /	/ /	/ /	/ /
P/DTaP/ TdT (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MM (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY) 3 MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
PATITIS 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

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

()



Informed Consent and Acknowledgment - COVID-19

A child care center is a community. During this public health emergency EACH member of our community needs to help keep COVID-19 out of our child care centers. Exposures in your center can lead to the closure of the entire center and impact all the families we are serving. We appreciate your partnership and commitment in this collective effort.

1. Partnership

I understand that I play a crucial role in keeping everyone in our child care community safe and reducing the risk of exposure by following the policies and practices outlined in this Informed Consent and Acknowledgment. I acknowledge that my family may be denied access to the center or disenrolled from the center for my failure or refusal to act in accordance with these provisions at all times, in a respectful and appropriate way.

2. COVID-19 Exclusion Policy and Health Check and Illness Policy-COVID-19

I have reviewed and am familiar with **Bright Horizons COVID-19 Policy** and **Bright Horizons Health Check and Illness Policy – COVID-19**. I agree to comply with these policies, as they may be updated or amended from time to time. Complete copies of these policies are available to me here: <https://www.brighthouse.com/covid19>. Should my child(ren) be excluded from the center pursuant to the terms of these exclusion policies, I understand tuition shall still be due and payable during any period of exclusion.

3. Reporting Confirmed Cases of COVID-19

I will immediately notify center administration if anyone in my household or any close contact of my household tests positive for COVID-19.

4. Exposure to COVID-19

I understand that to enter the center my ENTIRE household must be free from any known *or suspected* exposure to COVID-19. If my household has any known or suspected exposure to COVID-19, I **understand all members of my household may be required to remain out of the center for at least 10 days, until all criteria to return are successfully met**. I acknowledge that known/suspected exposures include (but are not limited to):

- A member of my household having a confirmed case of COVID-19
- A member of my household being tested or advised to be tested due to a known/suspected exposure to COVID-19
- A member of my household being directed to quarantine or self-isolate
- A member of my household having “close contact” with persons with known or suspected exposure to COVID-19

5. Negative Tests after Exposure

I understand that in the case of any known/suspected exposure, a subsequent negative test result will NOT reduce the time the household is required to remain out of the center. With respect to exposure due to travel, only the traveler will be excluded. In the case of domestic travel, the traveler may be eligible to return sooner if permitted in accordance with requirements of applicable local regulation, which requirements may include a negative test.

6. COVID-19 Symptoms

I understand to enter the center my ENTIRE household must be free from the COVID-19 symptoms listed below. **If COVID-19 symptoms are present in my household, I understand all members of my household will be required to remain out of the center for at least 10 days.** I understand this list of COVID-19 symptoms may be updated and that additional symptoms may be included by local authorities under applicable local regulation.

- Cough
- Sore throat
- *Fever of 100.4° or higher
- Muscle aches
- Difficulty breathing
- New loss of taste or smell

**Threshold may differ in certain localities*

7. Clearance to Return- Symptoms

If my household has been excluded from the center due to the presence of COVID-19 symptoms, I understand, under limited circumstances, I may be able to return to the center earlier if I can provide acceptable Clearance to Return from a medical provider (M.D., D.O., N.P., and P.A.) and the earlier return is permitted under any applicable local regulation. Clearance to Return will be acceptable if a medical provider assesses the symptomatic individual and provides written confirmation:

- there is an alternate diagnosis causing the COVID-like symptoms, or
- the symptomatic individual has tested negative, has been fever-free for at least 24 hours (without the use of fever-reducing medicines) and symptoms are resolving.

For clarity, an upper respiratory infection is not considered an acceptable alternate diagnosis and any unspecified diagnosis is presumed to be COVID. Clearance to Return must be provided by a third party and cannot be provided by a family member. Any exclusion for an exposure cannot be cleared by a medical provider. Any return to the center would remain subject to the requirements of the center's standard illness policy and compliance with the daily health screen requirements.

8. Daily Health Screen

I understand health screens will be conducted daily, either via a designated application or upon arrival. I will answer all health screen questions truthfully for myself, my child and for every other person in my household. I understand that a temperature check may be taken of each person dropping off/arriving.

9. Drop-off and Pick-up

For the safety of all those present in the center and to limit risk of exposure, I understand that I will not be permitted to enter the center beyond the designated drop-off and pick-up area. I understand that all adults are required to wear a face covering and are expected to respect social distancing requirements while at the center and while on center property.

10. Compliance

I will comply with all applicable legal requirements imposed, from time to time, on participants in child care programs.

11. Withdrawal

I understand that I must give thirty (30) days' notice before withdrawing my child (ren) from the center. If I accept enrollment and do not attend or if I withdraw upon less than thirty days' notice, I will be charged one month's tuition for the thirty day notice period.

12. Acknowledgment

I understand that my child will be in contact with children, families and staff who may also be at risk for community exposure. I understand that no restrictions, guidelines or practices will remove all risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I agree to use my judgment about what is best for my family and household, including undertaking additional precautions to protect the health of those in my household that may be at increased risk for severe illness from COVID-19.

I HAVE READ, UNDERSTOOD AND AGREE ON BEHALF OF ALL MEMBERS OF MY HOUSEHOLD AND ALL INDIVIDUALS AUTHORIZED TO PICK-UP MY CHILD TO THE CONDITIONS NOTED ABOVE.

Child(ren) Name(s):

Parent Name:

Signature:

Date:

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

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
--------------------	----------------------

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

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

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
--------------------	------

Rights of the Licensing Agency: Section 101200 (b) & (c)

The Department or Licensing Agency shall have the authority to interview children, or staff, and to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any children or staff members. The Department has the authority to inspect, audit, and copy child or child care center records upon demand during normal business hours. Records may be removed for copying if necessary.

Child's Name

Parent/Guardian Signature

Date

Center Director 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

PENINSULA REGIONAL CHILD CARE OFFICE

ADDRESS

851 TRAEGER AVE., STE 360, MS 29-24

CITY

SAN BRUNO

ZIP CODE

94066

AREA CODE/TELEPHONE NUMBER

650-266-8843

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)

BRIGHT HORIZONS / MARIN DAY SCHOOLS

(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: PENINSULA REGIONAL CHILD CARE OFFICE

Licensing Office Address: 851 TRAEGER AVE, STE 360, MS 29-24 SAN BRUNO CA 94066

Licensing Office Telephone #: 650-266-8843

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.

BRIGHT HORIZONS / MARIN DAY SCHOOLS
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

Medication Authorization Form

MEDICATION TYPE: ☐ PRESCRIPTION ☐ NON-PRESCRIPTION

Child's Name: _____ Date of Birth: _____

All medication must be provided in the original container, labeled with the child's full name. Where applicable, the implement for proper measurement must be provided and labeled with the child's full name. If not provided, medication cannot be administered. Non-prescription medications must be designated for use for children on the label.

I have read the *Medication Administration Policy* in the Bright Horizons Family Guide and I hereby authorize Bright Horizons agents to administer the following medication to my child.

Prescription Medications: must and have a current pharmacist's unaltered label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the medical provider. The instructions from the child's authorized representative shall not conflict with the label directions as prescribed by the child's medical provider.

Non-prescription Medication: with written authorization from parent/guardian can be administered according to the manufacturer's instructions. Written authorization from the child's medical provider is required for any deviation in manufacturer's instructions.

Standing Orders: with written authorization from the child's medical provider may be administered according to physician's instructions for a **period not to exceed six months**. Authorization must list the reason, dosage, instructions, start date and end date.

Medications for Chronic Illnesses: require a health care plan completed by the child's medical provider for a period not to exceed one year. Must include complete medication administration information, otherwise a completed Medication Authorization Form signed by medical provider is required (See Prescription and Non-prescription medication above for details).

Homeopathic/Herbal/Homemade Medications: with written authorization from parent/guardian can be administered according to the manufacturer's instructions. Written authorization from the child's medical provider is required for any deviation in manufacturer's instructions and to administer any homeopathic teething gels or tablets.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider.

On behalf of myself, my family and my minor child, I hereby release and agree to defend, hold harmless, and indemnify Bright Horizons Family Solutions LLC., its subsidiaries, affiliates, and employees, from any and all claims of injury or damage (including personal injury) as a result of any and all acts performed under this authority and according to the instructions below.

Medication: _____ Administration Route: _____

Reason for Medication: _____ Medication Storage: _____

Dosage: _____

Times of Administration: _____

Start Date: _____ End Date: _____

Side Effects: _____

Parent/Guardian Signature: _____ Date: _____

Physician's Name: _____ Physician's License Number: _____

Physician's Signature: _____ Date: _____

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	Treatment/Substitution
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission: ☐ Ingestion ☐ Contact ☐ Inhalation

Note: Do Not Depend on Antihistamines or Inhalers to treat a severe reaction. USE EPINEPHRINE.

Extremely Reactive to the Following Foods _____; therefore:

- ☐ If checked, give epinephrine for **ANY** symptoms if the allergen was likely eaten.
- ☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

For the following signs of a *mild* allergic reaction administer: _____

- ☐ **Skin:** Hives: Mild Itch ☐ **Nose:** Itchy, Runny, Sneezing
- ☐ **Stomach:** Mild Nausea/Discomfort ☐ **Mouth:** Itchy
- ☐ **Other:** _____

For any of the following signs of a severe allergic reaction or a combination of symptoms from different body areas, give Epinephrine and call 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. If breathing is difficult or vomiting, place on side, or sit up.

- ☐ **Mouth:** Significant Swelling of Tongue and/or Lips ☐ **Heart:** Pale, blue, faint, weak pulse, dizzy
- ☐ **Throat:** Tight, hoarse, trouble breathing/swallowing ☐ **Lungs:** Short of Breath
- ☐ **Skin:** Many hives over body, widespread redness ☐ **Stomach:** Repetitive vomiting, severe diarrhea
- ☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instructions: _____

Prescribed Medications/Dosage:

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Potential Side Effects of Medication: _____

Potential Consequences to Child if Treatment is Not Administered: _____

For MA centers only:

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____	_____
_____	_____
_____	_____

Physician Signature

Date

Parent/Guardian Signature

Date

Director/Principal Signature

Date

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s) ; or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

Parent/Guardian Signature

Date

*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Medication Authorization* form.

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

new!

California Car Seat Law Changes

EFFECTIVE JANUARY 1, 2017



NEW ADDITION

Starting January 1, 2017, children under 2 years old must be rear facing unless they weigh 40 pounds or more, or are 40 inches tall or more.

Children must be properly buckled in a car seat which is **rear facing** until age 2

CURRENT LAW

Children under age 8 must be buckled into a car seat or booster in the back seat.

Children age 8 or older, or who are 4'9" or taller, may use the vehicle seat belt if it fits properly with the lap belt low on the hips, touching the upper thighs, and the shoulder belt crossing the center of the chest. If children are not tall enough for proper belt fit, they must ride in a booster or car seat.

Everyone in the car must be properly buckled up.

Most children will outgrow an infant seat before age 1

- The next step is a convertible car seat.
- Rear facing is 5 times safer than forward facing.
- The American Academy of Pediatrics recommends that children ride rear facing to the highest weight or height allowed by the car seat manufacturer.

Kaitlyn's Law

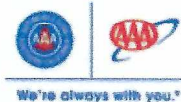
It's against California law to leave a child who is 6 years of age or younger alone in the car without the supervision of a person at least 12 years old if:

1. The keys are in the ignition or the car is running, or
2. There is a significant risk to the child.

FINES & PENALTIES

For each child under 16 who is not properly secured, parents (if in the car) or drivers can be fined more than **\$500** and get a point on their driving records.

Keep your children safe. It's the law!



For answers to your child safety seat questions, contact your local health department or visit cdph.ca.gov/vosp.