LOS ANGELES COUNTY/USC MEDICAL CENTER AUXILIARY
CARES CHILD & FAMILY PROGRAM
1200 N. STATE STREET, ROOM 1903, LOS ANGELES, CA 90033
TELEPHONE (323) 409-6976 Fax (323) 441-8393

Date: _______________

_____________________________ _______
Child's Name D.O.B.

________________________ ____________
Parent's Name Phone Number

CARES Child & Family Program
Inpatient Tower Child Care Application Check List

Medical Center employees, contract workers, students, etc. who are interested in applying for the CARES Child & Family Program, must remain on the LAC / USC Medical Center grounds while the child(ren) are receiving child care services. This is a license exempt program (campus based). Child care services are not an entitlement; therefore, parents must complete and provide the required enrollment forms to the CARES Child Care Office for review and approval. Please call to ensure that staff is available to assist you.

Child Care Services are provided at the Inpatient Tower Child Care Center, room 2L216, second floor. The hours of operation are Monday through Friday, 6:30 to 5:15 pm, closed county holidays. Child Care Services are provided once payment has been made.

Documents received:

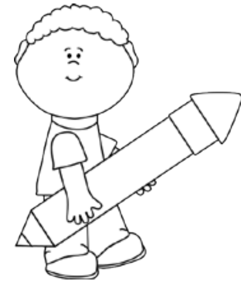
Date	Parent Initials	Office Initials		
				CHILD(REN) – 18 years or younger
_____	_____	_____	1.	**Enrollment Application** (for each child)
_____	_____	_____	2.	**Birth Certificate** (for each child) Other documents that can be used are Court orders regarding child custody, adoption documents, Foster Care / Guardianship documents, baptismal / christening certificates, tax returns identifying dependents
_____	_____	_____	3.	**Immunization record** (current for each child)
_____	_____	_____	4.	**Child's Exceptional Needs** (for each child in the program) including Individualized Education Program (IEP), Individualized Family Service Plan (IFSP) or any assessment documentation, etc.
_____	_____	_____	5.	**Picture, Video or Recoding Consent form** (for each child)
				PARENT/GUARDIAN* - may include relative who is residing in the home with the child(ren)
_____	_____	_____	1.	**Identification Badge** (County or Contract)
_____	_____	_____	2.	***Caregiver's Authorization Affidavit form**
_____	_____	_____	3.	***Parent Statement form** – authorizing the Caregiver's responsibility for the child
_____	_____	_____	4.	***Proof of residence** – legal document in Parent & Guardian's name
				PROGRAM DOCUMENTS
_____	_____	_____	1.	**Program Guidelines form**
_____	_____	_____	2.	**Parent Handbook- Policy Agreement-** *provided during orientation*

Office Orientation: Date: _______ Time: _____am/pm

Inpatient Tower Center Orientation: Date: _______ Time: _____am/pm

Child(ren) Start Date: __________

ENROLLMENT APPLICATION for CHILD CARE



Children of Medical Center employees' will be accepted on a temporary or continual basis. Employees may use the centers as a supplement to or substitute for sitters, school, etc. All fees are to be paid in advance at Inpatient Tower, Room 2L216. There will be an added charge of $25.00 for any check with insufficient funds and checks will no longer be accepted.

CARES offers:
* Planned Curriculum
* Parent Education
* Resource and Referral
* Infant Care
* Balanced Lunch and Snacks

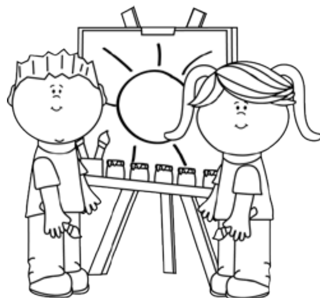
LOCATIONS AND HOURS:

Clinic Tower, Area A2A**,** Tel. (323) 409-3541…………..6:30 a.m.-5:15 p.m.
Inpatient Tower, Room 2L216, Tel.(323) 409-6940….6:30 a.m.-5:15 p.m.
Office, IPT Room 2L216, Tel. (323) 409-6976………..7:00 a.m.-10:00 a.m.*
**or by appointment*

ENROLLMENT POLICY: Tuition is due by the 15th of every month prior to the month of service. No tuition credits exist when employee or child is ill. The hours for which child care services are provided are based on the parents' work schedule.

FORMS: Parents will be required to fill out child's general information and health form prior to first visit. A copy of child's current immunization record must be kept in file.

HEALTH: Children who are sick will **not** be accepted.



FOR OFFICE USE ONLY:
Family Id # _________ Case #_________
Approved by: ________________________
Child Care Center: CT IPT
State Subsidized: ____Yes ___No
First Date of Enrollment: ______________

Child's Name (print): ______________________________ D.O.B. ______________________

Home Address: ________________________________ Home/Cell No. ( )______________

____ Pager No. ( ) ________________

Employee's Name: _______________________________ Employee ID#________________

Email Address: ____________________________________@___________________________

Work Location (Building & Room #): ____

Work Tel. ( ) ____________________ Alternate Work Tel. ( ) _____________________

<u>HEALTH CLEARANCE</u>

Does child have any physical condition that we should be aware of? _____Yes ______No

If yes, please explain: ____

Does child require special attention, medication, or routines that may have to be taken into

consideration in planning for his/her time in the center? _____Yes ______No

If yes, please explain: ____

Date of most recent physical examination? ____

Child's physician: _________________________ Phone Number: ( ) ___________________

Emergency hospital name: __________________ Phone Number: ( ) ___________________

____ ______________________

Signature of Parent / Guardian Date

CARES Child and Family Program
1200 N. State St., Room 1900 (General Hospital) Los Angeles, CA 90033, Tel (323) 409-6976

CHILD INFORMATION SHEET

Child's Name (print): ______________________________ D.O.B. ______________________

Race and Ethnicity (***check all that apply***):

Alaskan Native/American Indian _________ Asian _____________

Black/ African American _______ Native Hawaiian/ Other __________

Caucasian_________ Pacific Islander ______________

Language(s) spoken in the home: ____

Preferred Language(s): ____

Special Needs (***check all that apply***):

Child has IFSP (Individual Family Service Plan) or IEP (Individual Education Plan) _______

Child receives services through Regional Center or local School District___________

Social Emotional/behavior_______ Ongoing health problems________

Developmental delays__________ Speech/communication__________

Vision or hearing__________

Other (*please explain*) ____

School Age Children (***complete for school age children only***):

Grade_______ Name of School: ____

Name of School District: ____

PERMISSION TO PARTICIPATE IN PROGRAM ACTIVITIES AND TO RECEIVE EMERGENCY MEDICAL CARE

Child's Name: ________________________________ D.O.B.____________________

I hereby grant permission for my child to use all the play equipment and participate in all of the activities of the program, to be determined according to the child's developmental age.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to, the following:

1. We will take the child to the Emergency Room at the Diagnostic and Treatment Building.
2. Attempt to contact parent or guardian on Medical Center grounds at his/her work location or training site.
3. If parent or guardian who is on Medical Center grounds is not reachable, CARES will attempt to contact other parent or guardian through any of the persons listed on the Emergency Information form.
4. CARES will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
5. CARES will not assume responsibility for a child who has not been signed in when he/she arrives for child care.

___________________________________ ___________________________
*Signatur*e of Parent/Guardian #1: Date

___________________________________ ___________________________
Signature of Parent/Guardian #2: Date

Center (circle one): **CT** **IPT**

PERMISSION TO RELEASE CHILD IN CASE OF AN EMERGENCY

(In the event the Parent/Guardian is incapacitated at work)

Name of Child: ____ D.O.B. _______________
Last Name First Name Middle

Address: ___________________________________ Home/Cell No. (_____) _________________

_____________________________________ Pager No. (_____) _________________

Parent/Guardian #1: _____________________________ Work Days & Hours _______________
Last Name First
Place of Employment (Company Name, Dept./ Building & Room #): _______________________

____

Work Tel. 1 ( ) _________________________ Alternate Tel. ( ) _________________________

Parent/Guardian #2: ____________________________ Work Days & Hours ________________
Last Name First
Place of Employment (Company Name, Dept. / Building & Room #): _______________________

____

Work Tel. 1 ( ) _________________________ Alternate Tel. ( ) _________________________

Persons Authorized to pick-up child *(Cannot be Parent/Guardian enrolling child in program)*
Under no circumstance will the child be released to anyone not mentioned below**:**

(1)
____(____)_______________
Name Address City (circle one) Home/Cell Phone
Relationship to Child: ______________________________ Work Phone (____) _______________

(2)
____(____)_______________
Name Address City (circle one) Home/Cell Phone
Relationship to Child: ______________________________ Work Phone (____) _______________

____ ______________________________
Signature of Parent / Guardian Date

Shaded box below is to be **completed ONLY when child is released to an authorized person.** A new form must be completed by the parent prior to child's return to child care.

FOR CARES STAFF USE ONLY

______________________________________ ______________________________________
Signature of person picking up child Date

______________________________________ ______________________________________
ID Type and ID# Signature of CARES Staff

LOS ANGELES COUNTY/USC MEDICAL CENTER AUXILIARY
CARES Child and Family Program
1200 N. State Street, Room 1900
Los Angeles, CA 90033
(323) 409-6976 FAX (323) 441-8393

Picture, Video, or Recording Consent

It is the policy of the CARES Child and Family Program to obtain permission from the parent/guardian before allowing any picture, video, or recording to take place of a child at the Child Care Centers. If you do not feel comfortable giving us permission to use such photographs, video, or recording; please feel free to decline.

I hereby consent to having my child's picture to appear in electronic media (e.g. website) or public publications (e.g. newsletter, brochures, etc.) that CARES Child and Family Program might choose to release. In addition, pictures will assist teachers in documenting the progress of my child's development. I understand that his/her picture may be on display in accordance with any of the above mentioned activities. **Parent/Guardian Initials: _____________**

I hereby consent to having my child to appear in video or recordings that CARES Child and Family Program will use solely for training and evaluation purposes of their staff. **Parent/Guardian Initials: _____________**

If at any time, I want my child's photograph to be removed from electronic media or other publications, I acknowledge that it is my responsibility to inform, in writing, the CARES Child and Family Program of this decision. **Parent/Guardian Initials: _____________**

DECLINING:
At this time, I do not give CARES Child and Family Program permission to use my child's pictures for any school related electronic media or public publications. **Parent/Guardian Initials: _____________**

At this time, I do not give CARES Child and Family Program permission to have my child appear in video or recordings. **Parent/Guardian Initials: _____________**

Child's Name: ____________________________________ D.O.B.: _________________

Parent/Guardian Signature: _________________________ Date: ___________________