



TWO ROCK CHILD DEVELOPMENT CENTER  
*Where Learning is Child's Play*  
USCG Training Center Petaluma  
599 Tomales Rd, Petaluma, Ca 94952  
Telephone: (707)765-7334 Fax: (707)765-7093



Thank you for choosing our Child Development Center for your child care needs. This registration packet is for your child's enrollment. The following forms must be complete for your child to begin childcare:

- Child Development Services Registration Form, 2 pages (CG-5484)
- Child Development Services Child Health Form, 2 pages (CG-5484A) **Must be filled out and signed by your doctor.**
- Field Trip Permission/Photo, Video & Web Site Authorization, 1 page (CG-5484B)
- Medical Consent Authorization for Military Members, 2 pages (CG-5484H) **OR** Medical Consent Authorization for Civilian Members, 2 pages (CG-5484I) **Must be notarized. DO NOT fill out prior to seeing the notary.**
- Meal Benefit Form, 2 pages

Other documentation you will need to provide at the time of registration:

- Up to date **Immunization Record** including current flu vaccine
- Household income verification (LES and/or civilian paystubs)

Finally, you will need to call the front desk at 707-765-7334 to:

- Schedule a Parent Orientation
- Sign your contract

If you have questions about the registration process or about the Child Development Center, please feel free to call during business hours 0645-1700.

# CHILD DEVELOPMENT SERVICES REGISTRATION FORM

(See Privacy Act Statement on Page 2.)

Child's Name: \_\_\_\_\_  
(Last) (First) (MI)

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

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_  
(include Rank/Rate) Father Mother

Employers' Name/Address:

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Name of person(s) authorized to remove from child care (include phone number):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts in the event parent/guardian cannot be reached - Minimum of 2 local contacts in addition to parents required. (Name/phone number)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Doctor's name/phone number: \_\_\_\_\_

Any other information you believe would be helpful to caregiver in working with your child(ren):

\_\_\_\_\_

1. All parts of this form will be completed and signed by the sponsor before the child(ren) is admitted to the child care program.
2. This form will be kept on file for all children enrolled in a child care program.
3. A copy of the Emergency Medical Authorization form must be carried by staff if child is away from the site on a field trip so that emergency medical treatment may be obtained, if needed.
4. This form to be renewed at the beginning of each year.

Reset

**RELEASE OF INFORMATION/PRIVACY ACT STATEMENT**

Data required by the Privacy Act of 1974 (5 U.S.C. 552a)

Authority: 14 U.S.C. 632

Principle Purposes: To provide the care providers with authorization for medical treatment in required information emergency situations, identify children and sponsor, record immunizations and known allergies, and to provide other necessary for working with the child.

Routine Purposes: Form may be furnished to military or civilian doctor or hospitals in the course of obtaining medical treatment for children. Information furnished may be disclosed to any D component or part thereof, and upon request to other Federal, State, and local governmental agencies in the pursuit of their official duties.

Disclosure is Voluntary: The supplying of requested information is voluntary. Failure to respond will result in the denial of admission of your child to the program.

I release the information on the attached registration forms to the provider of child care services for the purpose of assessing the eligibility of the child(ren) for the program and for the routine uses listed above.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

**COLLECTION OF FINANCIAL DATA**

Principal Purposes: To access the proper fee to charge each participant using the facilities and programs at the Coast Guard Training Center Child Development Center

Routine Purposes: Information obtained from Federal Income Tax Forms, Leave and Earnings Statement and Employee Pay Stubs will be used to determine the combined total family income of patrons, in order to access the proper fee to charge for Child Development Center Services.

Disclosure Is Voluntary: The supplying of requested information is voluntary. Failure to respond or provide the requested information will result in charging the patron of the Child Development Center the fee associated with the highest Income Category.

I release the financial information to the Child Development Center Management for the purpose of determining the fees to charge my child(ren) for the programs at the Child Development Center and for the routine uses listed above.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

**CHILD DEVELOPMENT SERVICES**  
CHILD HEALTH FORM

**To be completed by a health practitioner before admission to a child care program and renewed annually.**

\_\_\_\_\_ has had a complete history and physical examination at my office on  
(Child's name: Last/First/Middle)

\_\_\_\_\_ . Findings for this child are indicated as follows:  
Date

1. Date of most recent tuberculin test \_\_\_\_\_ . Result: Positive \_\_\_\_\_ Negative \_\_\_\_\_

2. The child has the following which may significantly affect his education/care experience:

	YES	NO	COMMENTS
a. Visual problem	_____	_____	_____
b. Hearing problem	_____	_____	_____
c. Speech or language problem	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional, behavior problem	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments, and recommendations:

3. YES / NO The child has a health condition, which may require care or emergency action while he is at child care.  
(Please specify, e.g., seizures, bee sting allergy, diabetes, etc.)

Recommendations:

4. YES / NO The child has or is a known carrier of a communicable disease.

Explain:

5. YES / NO The child is on long term medication. Specify:

6. YES / NO The child requires a modified diet and/or special feeding procedures. Specify:

7. YES / NO The child is in good physical and mental health. Except as noted above, he is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

**ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:**

8. If child cannot fully participate in all areas of child care program, what areas should be limited or altered to suit this child's needs?

9. YES / NO Does child's physical activity need to be restricted? If YES, explain

10. What specialized treatments, if any, will this child require?

Instructions for care:

11. Does this child require any supportive equipment? (Braces, crutches, etc.) YES NO

If YES, please specify type \_\_\_\_\_

Special instructions for use \_\_\_\_\_

12. Additional comments:

**SIGNATURE & STAMP REQUIRED**

\_\_\_\_\_  
Health Practitioner (please print)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Signature of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

## FIELD TRIP PERMISSION

I give my permission for \_\_\_\_\_  
(child care provider) to take my child(ren) \_\_\_\_\_  
\_\_\_\_\_ (name) on field trips and/or other outings  
as long as my child(ren) is/are accompanied by competent supervision. These  
outings may be walking, motor vehicle, bicycle, etc.

**The above authorization shall remain in effect for one (1) year from below date,  
or until cancelled or amended by parent or legal guardian.**

\_\_\_\_\_  
(Signature of parent/legal guardian)

\_\_\_\_\_  
(Date)

### Photo, Video & Web Site Authorization

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

Date: \_\_\_\_\_

Below are three opportunities for the CDC to use photos of your child. Each opportunity is separate and requires your signature for us to use your child's photo(s) in individual media/formats. Participation is strictly voluntary, and the CDC staff will honor your wishes. You may decline part or all as you see fit. Please take a moment to carefully read and sign or decline each section. Thank you.

• CDC Pictures & Video Camera's: The CDC staff takes digital pictures of children to post on classroom walls, to use for assessment purposes, and to pass on to parents via email. We would also like to occasionally use video tape for special events, such as graduations and family functions. NAEYC encourages this to enrich our environments and to record special events. Please sign if we can take and use your child's photo as indicated above.

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

• Tracen Intranet Page: The Training Center maintains an internal webpage that is just for Coast Guard personnel. This page is for relaying information like the weekly calendar of base events, special programs members have participated in, and to recognize achievements of our diverse community. We would like to use this page for emphasizing events selected by the Command, along with the active duty members who participate. Please sign if we can post your child's picture on the Tracen intranet page.

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

• Tracen Petaluma Facebook page: The CDC has a facebook page where parent's can view events that are happening as well as pictures that are taken of the children at school. We find it is an easy way for the CDC to share pictures we take with parents. <https://www.facebook.com/pages/Coast-Guard-Training-Center-Petaluma/151701841511698> Please sign if we can post your child's picture on the Tracen Petaluma Facebook page.

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

**CHILD DEVELOPMENT SERVICES**  
MEDICAL CONSENT AUTHORIZATION

(TO BE USED BY MILITARY FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

TO: **HEALTH CARE PROVIDER**

I, \_\_\_\_\_, am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: \_\_\_\_\_, Age: \_\_\_\_\_

Address: \_\_\_\_\_, Phone: \_\_\_\_\_

\_\_\_\_\_, ID Card # \_\_\_\_\_

\_\_\_\_\_, Exp. Date \_\_\_\_\_

\_\_\_\_\_  
(Sponsor's Name)

\_\_\_\_\_  
(Employee ID Number)

\_\_\_\_\_  
(Duty Station)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the Petaluma Valley Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the Petaluma Valley Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on \_\_\_\_\_, 20\_\_\_\_ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**CHILD DEVELOPMENT SERVICES**  
MEDICAL CONSENT AUTHORIZATION

(TO BE USED BY CIVILIAN FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

**TO: HEALTH CARE PROVIDER**

I, \_\_\_\_\_, am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: \_\_\_\_\_, Age: \_\_\_\_\_

Address: \_\_\_\_\_, Phone: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_  
(Insured Person's Name)

\_\_\_\_\_  
(Employee ID #)

\_\_\_\_\_  
(Employer Name)

\_\_\_\_\_  
(Employee Address)

\_\_\_\_\_  
(Insurance ID Card #)

\_\_\_\_\_  
(Insurance Effective Date)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the Petaluma Valley Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the Petaluma Valley Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on \_\_\_\_\_, 20\_\_\_\_ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date





**4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE**

**(PENALTIES FOR MISREPRESENTATION:** I Certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, Kin-GAP, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	<input type="checkbox"/> Check here if no SSN
Signature of Adult:	Date:

**PRIVACY ACT STATEMENT**

The Richard B. Russel National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, Kinship Guardian Assistance Payment Program (Kin-GAP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, FDPIR, or Kin-GAP office to determine current certification for CalFresh, CalWORKs, FDPIR, or Kin-GAP benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

**5. RACIAL/ETHNIC IDENTITY**

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following <b>racial</b> identities:		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White
Please mark one of the following <b>ethnic</b> identities:		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	