FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: ______________________________

   Licensing Office Address: ______________________________

   Licensing Office Telephone #: ______________________________
8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (8/08) (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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee.______________________________

Name of Family Child Care Home

Signature (Parent/Authorized Representative) ______________________________Date____________________

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

Immunizations (shots) Needed Before Starting Child Care/Preschool

Age When Entering	Immunizations (shots) Required
2–3 Months	1 each of Polio, DTaP, Hib, Hep B
4–5 Months	2 each of Polio, DTaP, Hib, Hep B
6–14 Months	3 each of DTaP 2 each of Polio, Hib, Hep B
15–17 Months	3 each of Polio, DTaP 2 Hep B 1 MMR on or after the 1st birthday 1 Hib on or after the 1st birthday
18 months–5 years	3 Polio 4 DTaP 3 Hep B 1 MMR on or after the 1st birthday 1 Hib on or after the 1st birthday** 1 Varicella

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE 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
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ 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?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*

WORD USED FOR “BOWEL MOVEMENT”*	WORD USED FOR URINATION*

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD’S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR’S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD’S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE 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
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST MIDDLE FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER STREET CITY STATE ZIP		HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST MIDDLE FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER STREET CITY STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST 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 PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

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

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

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
( )	( )

License #493009653

Release and Hold Harmless Agreement

I ____, have read, and understand that this Agreement is a waiver of any and all liability(ies). I understand the potential dangers that could incur to myself or my child/charge, in mounting, riding, walking, grooming, feeding, handling, boarding any horse(s) including but not limited to any interactions with any other ranch animals, other horses, riders, students, camp participants, camp counselors, teachers, care providers, party attendees and visitors.

I understand all risks and I hereby release Kristine Sheets Stewart and Crossroads Ranch, its officers, directors, shareholders, employees and anyone directly or indirectly connected with said company from any and all liability whatsoever in the event of damage or injury (or even death) to myself or my child/charge or anyone else caused by or incidental to myself or my child/charge electing to mount and ride a horse owned and/or operated by Kristine Sheets Stewart and Crossroads Ranch.

I warrant that this Release and Hold Harmless Agreement has been read by me and is being voluntarily and intentionally signed and agreed to and that in signing I understand, recognize and know that this Release and Hold Harmless Agreement may further limit the liability of equine professional(s) to include any activity whatsoever around or involving any horses, other animals, equipment, structures, furnishing on and around Crossroads Ranch including damage to property, personal injury and/or/including death..

I recognize and agree that I know which equine professionals I, myself or my child/charge will be working with, and acknowledge that I agree said equine professional(s) has/have made reasonable and prudent efforts to determine my ability to engage in the equine activity and has/have sufficient knowledge of my or my child's/charge's equine and/or horseback riding skills and experience as to relieve, release and hold harmless said equine professional(s) from a any continuing duty to monitor my or my child's/charge's equine activities.

I further voluntarily agree and warrant to Release and Hold Harmless Agreement Kristine Sheets Stewart and Crossroads Ranch from any liability whatsoever, including but not limited to, any incident caused by or related to professional(s) negligence, relating to injuries known, unknown or otherwise not herein disclosed; including but not limited to including, damage to property, personal injury and/or/including death from the mounting, riding, dismounting, walking, grooming, feeding, petting, standing or walking beside a horse owned and/or operated by Kristine Sheets Stewart and Crossroads Ranch.

I also further voluntarily agree and warrant to equine activities this/these equine professional(s) from any liability whatsoever, including but not limited to, any incident caused by or related to said equine professional(s) negligence, relating to injuries known, unknown or otherwise not herein disclosed; including but not limited to including the use of horse barn, paddock, trails or riding ring in any capacity; falling off of horse whether horse is bucking Ęipping, spooked, or my or my child's/charge's failure to understand any directions or instructions given by said equine professional(s) related to my or my child's/charge's equine activities, including but not limited to riding or otherwise use and control or lack thereof, of the horse(s) I may be assigned to.

_______________________________________ ______________________

Signature Date

_______________________________ _______________________________

Your Name (Print) Participant's Name (Print)

License #493009653

Waiver of Liability

This Waiver of Liability relates specifically to the property owned by KRISTINE SHEETS STEWART and JAIME STEWART known as CROSSROADS RANCH, License #493009653 at the address of 490 Formschlag Lane, Penngrove CA 94951 (“The Property”).

I agree to hold KRISTINE SHEETS STEWART and/or JAIME STEWART individually and as co-owners of The Property harmless from any and all claims arising out of any injury sustained as a result of my involvement, participation, and/or proximity to any animals, gear, tools, equipment, buildings, fencing , landscaping , and/or paraphernalia that is set up on, around or associated with The Property.

Further, I fully understand that there is a risk of injury involved in any activity on a ranch as aforementioned, and I expressly and fully assume the risk of all injuries and waive my rights to assert any claims for bodily injuries or property damages arising out of/or in any way relating to my involvement and/or my association to activity(ies) on The Property.

I speciĕcally understand that this waiver forfeits my right to assert a claim in a court of law and waives my right to a jury trial for any such claims. I understand that I am not required to execute this waiver and release. I choose to do so under my own free will.

____ ________________________

Signature Date

________________________________ ________________________________

Your Name (Print) Participant’s Name (Print)

License #493009653

Photo Image Use Release

In consideration of the minor named below, and for other good and valuable consideration that I acknowledge as having received, I hereby grant the following rights and permissions to KRISTINE SHEETS STEWART and CROSSROADS RANCH, License #493009653 for taking photographs and for keeping said photographs.

I agree that the minor's own name will not be used, but that KRISTINE SHEETS STEWART and CROSSROADS RANCH has the absolute right and permission to take, keep, use, reuse, publish, and republish photographs or pictures of the minor named below or in which the minor may be included, in whole or in part, without restriction as to changes or alterations from time to time to be used in both print and digital form in marketing and/or advertising materials for KRISTINE SHEETS STEWART AND CROSSROADS RANCH.

Reproductions of such photographs in color or otherwise, may be made and used through any medium, and in any and all media now and hereafter known connected with KRISTINE SHEETS STEWART AND CROSSROADS RANCH.

I specifically consent to the digital compositing, adjustment, or distortion of pictures, including without restriction any changes or alterations as to color, size, shape, perspective, context, foreground, or background. I waive any right that I or the minor have to inspect or approve any finished product or products or the advertising copy or printed matter that may be used in connection with such photographs or the use to which it may be applied.

I hereby warrant that I am a legal competent adult and the parent or legally appointed guardian of the minor named below and that I have every right to contract for the minor in the above regard.

I state further that I have read the above authorization, release, and agree that I am fully familiar with the content of it. This release shall be binding upon the minor, me, and our respective heirs, legal representatives, and assigns.

______________________________	______________
Name of Minor (Print)	Date of Birth
Signature of Minor (if over the age of 14 years)	Date
Signature of Parent of Legal Guardian	Date

License #493009653

Camp Participant Information and Registration   Camp Dates ______________________

Name of Participant ____ Age ________
School ____ Grade ____________
Parent/Guardian Name(s) ____
Address ____
Phone ________________ Phone ________________ Email ____________________

Participant's Equine Experience

Participant has previously ridden a horse? YES NO If yes please describe or explain: ____________________
____
____

Participant's Medical Information

Does Participant take any medication? YES NO If yes please describe or explain: ____________________
____

Will they be taking this at camp? YES NO If yes please give instructions: ____________________
____

Does participant have any medical conditions, limitations or problems? YES NO If yes please describe or explain:
____

List any/all allergies (food, bee sting, medications, etc.) ____________________________

Date of last Tetanus Shot ______________ Medical/Dental Insurance Information ____________________
____

Name of Doctor: ______________________________ Phone ______________
Name of Dentist: ______________________________ Phone ______________

Medical Release

I/We, the parent(s) or legal guardian(s) of ____
give consent and permission to Kristine Sheets Stewart to render first aid to my child/charge, to administer medicine, to summonan ambulance, or otherwise provide transport for my child for emergency medical care.

Emergency Contact Name: ______________________________ **Phone** ______________
Emergency Contact Name: ______________________________ **Phone** ______________

Parent/Guardian Signature: ______________________________ **Date:** ____________

NOTICE: Payments can be made with cash, check or Venmo. Payment in full is due with this registration and is non-refundable and non-transferable. If a session needs to be canceled, a credit can be applied toward future Drop Off sessions (outside of Summer Camp sessions) if a written cancellation notice is received no later than 30 days prior to the start of the session being canceled.

License # 493009653

Horseback Riding Participant's Information

24 HOURS NOTICE IS REQUIRED FOR ALL CANCELLATIONS AND THE FULL FEE MUST BE PAID AT THE TIME OF NEXT RIDE

Name of Participant ____ Age __________
If a Minor - Parent/Guardian Name ____
Address ____ Phone __________________________
Email ____ Cell ____________________________
Emergency Contact _________________________________ Phone _________________________
Relationship to Participant ____

Equine Experience
Has Participant previously ridden a horse? ________ If yes please describe or explain ____
____
____
____

Medical Informion
Does Participant take any medication? _______ If yes please describe and explain ________
____
____
Does participant have any medical conditions, limitations or problems? ________ If yes ___
please describe and explain.____
____
____
List all allergies (foods, bee sting, medications)_______________________________________
____ Date of last Tetanus Shot ________________
Medical/Dental Insurance Information ____
____
Name of Doctor ____________________________________ Phone _______________________
Name of Dentist ____________________________________ Phone _______________________

Medical Release
I the Participant (or) we, the parent(s) or legal guardian(s) of the Participant give full consent and permission to Kristine Sheets Stewart to render first aid to me (or) my child/charge, to administer medicine, to summon an ambulance, or to provide transport to a hospital where I (or) my child/charge may receive appropriate emergency medical care.

Signature ____ Date ___________________