ENROLLMENT APPLICATION PROCEDURES
(310) 900-1600 ext. 2902

INSTRUCTIONS
The following documents are required prior to the child's/family enrollment. Please use ink pen for signing.

1. Physical Examination Form completed and signed by the doctor along with a proof of TB Skin results.
   Los siuientes documents son requeridos antes de la inscription del niño.
2. Verification of current cash aid benefit from Welfare Grant of the Department of Public Social Services or a copy of Notice of Action Form.
   Verificacion de ayuda de Welfate de el DPSS o copia de la nota de accion.
3. (a) Recent check stubs covering last three months pay period if employed.
   (b) Employment Form to be completed by your employer only (this form will be provided to you by the program).
   Un talon de cheque, que sea resiente (si esta trabajando).
4. A copy of Child's Immunization Record, TB skin test and results
   Copia del record de vacunas del menor.
5. Copy of child's Medi-cal Card, or Health Insurance Card; (i.e.; Kaiser, Blue Cross, Signa & etc.).
6. Current California ID/Driver's License.
7. Father's information
8. Education Plan from Counselor
9. Copy of Child's Original Birth Certificate (All children in the household).
10. Copy of parent and child social security card.
11. 2 copies of class schedule and training verification form, stamped by Admissions and Records office, or CalWork office.

- All required forms must be completed and signed before you turn in your application.
  Todos las formas requeridas deveran estar completas y firmadas.
- Please submit copies of original documents only!
  Por favor entrique copias de documentos originales.
- All items will become the property of Compton Community College District Abel B. Sykes, Jr., Child Development Center and will not be returned.
  Todos los documentos pararan a ser propiedad de este centro y no seran devueltos.

Note: Please make sure that your application is completely filled-out and that all required documents are signed and submitted. An incomplete application will delay the enrollment process.

ABEL B. SYKES, JR., CHILD DEVELOPMENT CENTER

CONFIDENTIAL APPLICATION FOR CHILD DEVELOPMENT SERVICES AND
CERTIFICATION OF ELIGIBILITY

Section V:

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge. ______ Initial

I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services. ______ Initial

I understand that the information about my eligibility may be reviewed by representatives of the State of California, the federal government, independent auditors, or others as necessary for the administration of the program. ______ Initial

I understand that if the agency denies this application for services, I have the right to appeal.
______ Initial

I understand that I must renew my eligibility at least once a year (at least or every six months for protective services children). I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized childcare services for my child. ______ Initial

I understand that I will receive a notice of approval or disapproval on my application within 30 days from the date I sign this form. ______ Initial

I understand that this certification is not complete until all documentation submitted and this form has been reviewed, signed, and dated by the agency representative and signed and date by me. ______ Initial

_____________________________________ _________________________
Verified Date

Confidential Application for Child Development Services and Certification of Eligibility

Form CD 9600, Page 1, (REV. 03/04)

Agency Name: ______________________________
Family Identification/Case No.: ______________________________
Initial Subsidized Service Date: ______________________________
Type of Application: (Check one) Initial ☐ Recertification ☐

Note: State regulations require a formal application and certification for child development services. You will receive written notice of your eligibility no later than 30 days from the date of your signature on this form. Eligibility is determined on the basis of need for child development services and either CalWORKs status or adjusted gross monthly income in relation to family size. This form must be completed by an agency representative in consultation with the family. Refer to the instructions for the completion of this form.

Section I. Family Identification. If you are a single parent/caretaker, check this box: ☐ See Instructions, Section I.

Name of parent/caretaker (full name, including middle initial) A	Social Security Number - parent A* (See instructions.)	Gender	Phone no. (home)	Phone no. (work/school)
Name of parent/caretaker (full name, including middle initial) B		Gender	Phone no. (home)	Phone no. (work/school)
Street address	City	State	Zip	FIPS code

Section II. Family Eligibility and Reason for Needing Service

A. Family Eligibility Status (Check as many as apply)

	Protective services (attach documentation.)		Income eligible (attach documentation.)		Homeless (attach documentation.)		Programs for the severely handicapped (GHAN)

B. Reason for Needing Service. Indicate all the reasons for needing care for each adult listed above. Enter "A" or "B" referring to parent/caretaker listed above. Attach documentation. (This section does not apply to state preschool programs [GPRE] or programs for severely handicapped [GHAN].)

Parent/ Caretaker	Reason for Needing Service	Parent/ Caretaker	Reason for Needing Service	Parent/ Caretaker	Stages 1, 2, and 3 CalWORKs recipients only	
	Child referred for protective services because of neglect, abuse, exploitation, or risk thereof		Education or training		CalWORKS activities	Date family became ineligible for aid:
	Parent/caretaker incapacitated because of medical or psychiatric special needs		Actively seeking employment		Diversion	Date: ____________
	Working		Seeking permanent housing	Record date of entry into each stage: Stage 1________ Stage 2________ Stage 3________		

C. Employment/Training Information. Must be completed for each adult listed in Section I above to document need on the basis of employment or training. (Attach documentation.)

Parent/ Caretaker	Employer/School		Street Address			City	Zip
A							
A							
Days and working/ training hours:	From: To:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Parent/ Caretaker	Employer/School		Street Address			City	Zip
B							
B							
Days and working/ training hours:	From: To:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Section III. Family Adjusted Gross Monthly Income and Size

A. Family monthly income. The family's adjusted monthly income from all sources (Attach verification and documentation.): $_______________
B. Family income sources (Check all that apply. Do not count the gray shaded areas in Section III. A above.) **Black shaded boxes for CalWORKs recipients only.**
C. Family size (See "Funding Terms and Conditions" for instructions on calculating family size.): __________________

	Employment, including self-employment		Other federal cash income programs (such as SSI)
	Child support		Housing voucher or cash assistance
	Cash or other assistance under Title IV of the Social Security Act (TANF)		Assistance under the Food Stamps Act of 1977
	State-only alien and two-parent programs for CalWORKs recipients		Other

Section III B is for federal data collection purposes only and does not need to be completed before the provision of child care services.

Confidential Application for Child Development Services and Certification of Eligibility

CD 9600 Page 2 (REV. 03/04)

Section IV. Data on Children. List all children residing in the home and counted in the family size.

Complete for all children residing in the home				Complete only for children served by your agency					For children enrolled in more than one program or site, use additional lines as needed										
(1) Full Name of Child Including Middle Initial	(2) Gender		(3) Birth Date	(4) Adjustment Factor Code	(5) Ethnicity	(6) Race	(7) Native Language		(8) Program Code	(9) Type of Care Code	(10) Hours of Care per Day								
	M	F	MM/DD/YYYY				Lan-guage Code	Is child limited English proficient?				M	T	W	TH	F	SAT	SUN
											S							
									Provider/site name:		V							
											S							
									Provider/site name:		V							
											S							
									Provider/site name:		V							
											S							
									Provider/site name:		V							
											S							
									Provider/site name:		V							
											S							
									Provider/site name:		V							

Section V. Certification and Signature of Parent/Caretaker.

1. **I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.**
2. **I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services.**
3. **I understand that the information about my eligibility may be reviewed by representatives of the state of California, the federal government, independent auditors, or others as necessary for the administration of the program.**
4. **I understand that if the agency denies this application for services, I have the right to appeal.**
5. **I understand that I must renew my eligibility at least once a year (at least once every six months for protective services children). I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized child care services for my child.**
6. **I understand that I will receive a notice of approval or disapproval of my application within 30 days from the date I sign this form.**
7. **I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, and dated by an agency representative and signed and dated by me.**

Signature | Date

Relationship to Child: ☐ Parent ☐ Grandparent ☐ Guardian ☐ Foster Parent ☐ Other: Please describe ________________

Section VI. Family Fee (See fee schedule.).

Type of Fee	Full Time	Part Time
A. Daily fee (if any)		
B. Hourly fee (if any)		

Section VII. For Office Use Only. (Certification is not complete until eligibility is reviewed, signed, and dated by an agency representative.)

Eligibility Status ☐ Accepted ☐ Denied		Date Notice of Action Sent (Attach copy)	Date Notice of Action Given (Attach copy)	First date of subsidized service	Last date of enrollment
Signature of Authorized Agency Representative			Title	Telephone number	Date
Signature of Supervisor (Optional)			Title	Telephone number	Date

CALIFORNIA DEPARTMENT OF EDUCATION
Form CD 9600A, (Rev. 01/04)

Child Care Data Collection
Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who receive child care assistance. The information will be reported to the California Department of Education (CDE) and then to HHS. The information will be used for research on the status of child care in the United States and will provide valuable data to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, the Legislature, other governmental agencies, or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the Social Security Number of the head of the family unit receiving child care assistance. If you do not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated in Section 98.71(a)(13) of *Title 45* of the *Code of Federal Regulations*, *Education Code* Section 8261.5, and Section 18070 of *Title 5* of the *California Code of Regulations*. Your decision to provide your Social Security Number is voluntary.

I have been informed of the way my Social Security Number will be used. I understand that if I do not wish to give my number, I can still receive child care assistance.

☐ YES, my Social Security Number may be used: _______-_____-_______

☐ NO, I do not wish to give my Social Security Number for this purpose.

______________________________ ______________________
Signature of the Head of Household Date

____
Type or Print Name

You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Child Development Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

EMERGENCY AND IDENTIFICATION INFORMATION
Identificacion y Informacion Emergencia
(to be completed by Parent or Guardian/Dada por Padre o Guardian)

Child's Name:
Nombre de Niño/Niña: ______________________

Child's Birthdate:
Fecha de Nacimiento: ______________

Street Address:
Direccion: ______________________

City:
Ciudad ______________

State:
Estado: CA

Zip Code: ______________

Child's Social Security #:
Niño/Niña Social Security #: ______________

Mother's Name:
Nombre de Madre: ______________________

Telephone #:
Telefono #: ______________

Father's Name:
Nombre de Padre: ______________________

Telephone #:
Telefono #: ______________

Person responsible for child during the day/Persona responsible por el niño durante el dia?

Name:
Nombre: ______________________

Telephone #:
Telefono #: ______________

Address:
Direccion: ______________________________________

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY
Personas addicionales quien puedemos hablar en caso de emergencia

Adult's Name *Adulto's Nombre*	Address *Direccion*	Telephone #: *Telefono #:*	Relationship *Relacion*

PHYSICIAN TO BE CALLED IN AN EMERGENCY
Doctor a quien podemos hablar en caso de emergencia

Physician's Name: ______________________ Telephone #: ______________

Address: ______________________________________

If your physician cannot be reached what action should be taken?
Si el doctor no se puede encontrar que accion podemos tomar? ______________

Call Emergency Hospital/*Llamar hospital de emergencia?* ______________

Other/*Otro*: ______________________________________

NAME OF PERSONS AUTHORIZED TO TAKE CHILD FROM CENTER
Nombre de personas autorizadas para levanter el niño/niña del centro
(Child will not be allowed to leave with any other person without written authorization from parent or guardian/no puedra dejar el centro con ninguno persona sin permiso escribido de padre or guardian)

NAME/NOMBRE	RELATIONSHIP/RELACION

Time child will be picked up/Hora que el niño sera levantado? ____________________

______________________________________ ________________
Signature of Parent or Guardian/Firma de Padre or Guardian Date/Fecha

This part is to be completed by the Director or Designee of Abel B. Sykes, Jr., CDC

____
Date of Admission/Fecha de Admicion

____
Date Terminated/Fecha de Terminar

____
Signature of Person Authorizing Admission

PHYSICAL DEVELOPMENT/CASE HISTORY

Desorroyo Physico/Casa deHistoria

Teacher: ______________________ Room/Centro #: __________ Date/Fecha: __________

Child's Name/Nombre de Niño: ______________________ Address/Direccion: ______________________

______________________ City/Ciudad: ______________ Telephone/Telefono: ______________

Birth Place/Lugar de Nacimiento: ______________________ Ethnic: ______________ Sex/Sexo: ______

Father's Name/Nombre de Padre: ______________________ Occupation/Ocupacion: ______________________

Home Address/Direcion: ______________________ Telephone/Telefono: ______________

Father's Age/Edad de Padre: __________ Birth Place/Lugar de Nacimiento: ______________________

Mother's Name/Nombre de Madre: ______________________ Occupation/Ocupacion: ______________________

Home Address/Direcion: ______________________ Telephone/Telefono: ______________

Mother's Age/Edad de Madre: __________ Birth Place/Lugar de Nacimiento: ______________________

Name and Ages of Brothers and Sisters/Nombres y Edad de Hermanos y Hermanas

Name of other relatives living in home/Otros familiars que viven en la casa (Names & Relationship/Nombres y Relaciones)

Who cares for child if mother is employed?/Quien se encarga del nino si la madre trabaja?

____

Emergency Telephone/Telefono de Emergencia:

(   )

Doctor's Name/Nombre de Doctor:

____

Doctor's Address/Direccion:

____

CHILD PHYSICAL DEVELOPMENT/DESORROYO PHYSICO DE NIÑO

Was there any injury or diseases during pregnancy?/Accidentes o entermedades durante embarazada? (describe/describa)…

____

____

____

Was child's birth normal/Condicion de nacimiento? __________ Yes __________ No

Was there prolonged labor/Labor prolonganda? _________ Yes _________ No

Was child born prematurely? _________ Yes _________ No

Nature of delivery/Modo de nacer? ______________________________

Child's birth weight/Peso an nacer: ______________________________

WHAT AGE DID CHILD/AGUE EDAD:

Stand with support/Empezo caminar sin ayuda? ______________________________

Roll over while lying in a crib/Rodo solo en su carnita? ______________________________

Started crawling/Gatio? ______________________________

General health of child/Salud en general de la criatura ? ______________________________

Hearing/Sentido de Oir? ______________________________

Sight/Vista? ______________________________

What illnesses, operations or injuries has child had and at what age and length?/*Que enfermedades, operaciones, golpeadure a tenido la criatura, a que edad y por cuanto tiempo:*

Physical abnormalities/*Alguna abnormalida physica*? (If so, explain/*Si asi es, explice*):

Describe the following:	**Good/Excelente**	**Average/Mejor**	**Poor/Pobre**
How are child's eating habits/Describa el modo de comer			
How are child's sleeping habits/Describa el modo de dormer			
Child's attitude toward adults/Acittud contra adultos			
Child's ability to follow directions/Abilida de sequir rutinas			
Is child able to recall of songs, stories/Recuerda canciones, estorias			
Reasoning ability/Abilida de razonas			
Is child able to express self to others/Puede ecpresarze con otros			
	Too Wild/Muy Loca	**Average/Poca**	**Not at All/Nada**
Is child curios?/Curiosida			
Imagination/Imaginacion			
	Yes/Si	**No**	
Has child lived in more that one area/Ah vivido en esta el niño/niña?			
Has child traveled a great deal/Ah viajado mucho el niño/niña?			
Does child play alone/Juega solo/sola			
Does child play with others/Juega con otros			
Does child wet the bed/Urina la cama			
Does child have any allergies/Alergoas			
Does child suck finger/Chupa los dedos			

Length of attention span/Cuanto tiempo dura la attencion _____ 10 _____ 15 _____ 20 _____ 25 Minutes/Minutos

What language spoken in the home/Que idioma habla en casa? ____ English ____ Spanish ____ Other ____________________

Child's speaks in/El niño/niña responde en/con: _______ One word response/Una palabra _______ Phases/Frases _______ Sentences/Respua complea

Means of discipline/Modo de discipline: ____

Reaction to discipline/Reaccion a dicipline: _____ Hostile/Pelia _____ Rebellious/Rebelde _____ Withdrawns/Se envelble

Record any other physical activity skill parent desires/Escriba otra activida physica que el padre deseya:

____

____

NUTRITION INFORMATION/NUTRICION INFORMACION

An important objective of the Child Development Center's meal time is to help each child learn to enjoy eating nutritious/healthy food.

In order for us to achieve this objective, we would like to have the following information about your child's eating habits:

El mas importante objecto de la hora de comer del Centro de Desarroyo de niños/niñas es ayudar cada niño aprende augsraie a comer y para entender que comer es un experencia agradable.

Para modo que nosotros consigamos este objecto queremos sabet la siguente informacion de los modos de comer de su niño.

Child's Name/Nombre del Niño/Niña: ____________________

Favorite Food/Comida Favorita: ____________________

Foods Liked/Comida que le gustan: ____________________

Foods Disliked/Comidas desagradables: ____________________

Amount of Food usually eaten/Cantidad decomida que siemre come: ____________________

Foods Not eaten because of ALLERGIES/Comidas qe no puede comer por ALLERGIAS: __________

Foods Not eaten because of RELIGION/Comidas que no puede comer por RELIGION: __________

Does child eat fast or slow/Su niño come pronto o despacio? ____________________

What is family's eating schedule/A que horas come la familia? ____________________

Additional information yo feel we should know/Informacion addicional que uste crea que debemos saber?

____

____

______________________________ ____________________

Parent Signature/Firma de los Padres *Date/Fecha*

CONSENT FORM

I hereby authorize my child/children whose name(s) is/are ______________________________ to participate in on campus and off campus educational field trips and/or excursions sponsored by the Compton Community College District Abel B. Sykes, Jr., Child Development Center through the school year.

I understand that I will be notified in writing prior to each event that is to take place off campus.

_______________________________________ ____________________

Parent Signature *Relationship to Child*

FORMA DE PERMISO

Yo doy autorizacion que me hijo/hijos cuales nombre(s) es/son ___________________________ que participe en lugares de la escuela y afuera de la escuela en paseos o excurciones educacionales mandados por la escuela de desarroyo del Collegio en Compton por todo del ano escolar.

_______________________________________ ____________________

Firma de los Padres *Relacion del niño/niña*

PARENTAL PERMISSION

Taking of Photographs

I _________________________________, hereby authorize the Compton Community College
(Parent's Name)
District Abel B. Sykes, Jr., Child Development Center to take photographs of my child, _______________________________, during Educational Field Trips and during center's hours
(Child's Name)
of operations.

I understand that these photographs will be for the center's use only.

____ ________________________

Parent Signature *Date*

PERMISO DE LOS PADRES

Tamando Fotos

Yo ___________________________________, autorizo la Centars que tome foto de mi niño(a),
(Nombre del Padre)
__________________________________, durante Viajes Educacionales y drante su estancia en
(Nombre del Niño)
el programa.

Entiendo que estos fotos son para el uso del centro de niños unicamento.

____ ________________________

Firma de los Padres *Fecha*

CHILD'S PREADMISSION HEALTH – PARENT'S REPORT

Child's Name	Sex	Date of Birth
Father's Name	Age	Does the father live in home with child?
Mother's Name	Age	Does the mother live in home with child?
Has the child been under regular supervision of a physician?		Date of last examination:
DEVELOPMENTAL HISTORY		
Walked at: ________months	Begin talking at: __________months	Toilet training started at _____________months

ILLNESSES – Check those illnesses that the child has had and give approximate dates:

	Dates		Dates		Dates
☐ Chicken pox ☐ Asthma ☐ Rheumatic fever ☐ Hay fever		☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Mumps		☐ Poliomyelitis ☐ Ten-day measles(Robeola) ☐ Three-day measles (Rubella)	

Other serious or sever illnesses or accidents?

Does child have frequent colds?	How many in last year?	List any allergies staff should be aware of:
DAILY ROUTINES		
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:	Breakfast: Noon Meal: Evening Meal:	What are usual eating hours:

Any food dislikes?	Any eating problems?
Are bowel movements regular? ☐ Yes ☐ No	What is the usual time?
Word used for: Bowel Movement?	Urination?

Parent's evaluation of child's health?

Parent's evaluation of child's personality?

How does the child get along with parents, brothers, sisters, and other children?

Has the child had group play experiences?

Does the child have any special problems or fears? (explain)

What is the plan for care when the child is ill?

Parent Signature	Date

State Department of Education
Child Development Division

CHILD'S PREADMISSION HEALTH EVALUATION
PHYSICIAN'S REPORT

Statement of Physician

______________________________, born, ___________________is being studied for readiness to
(Name of Child) (Date of Birth)
enter ____________________________. This child care center provides a program which extends from ___________a.m. to ____________, ____________days a week. The daily activities include vigorous outdoor play and play with groups of ________ children. The schedule includes morning and afternoon snacks of _____________________________, a noon meal, a nap of ______ hours after lunch.

Will you please provide a report on the above-named child, using the form below?

(Signature of parent, guardian, or other responsible party (Date)

PHYSICIAN'S REPORT

The above-named child ☐ is ☐ is not physically and emotionally able to participate in the child care program described above.

Comments:

Child's physical conditions requiring special attention in the child care center:

Medication prescribed or special routines which should be included in the child care plan for child's activities:

IMMUNIZATION HISTORY

Vaccine	Date each dose was given (month and year as a minimum)				
	1st	2nd	3rd	4th	5th
Polio					
DTP or Td					
Measles					
Rubella					
Mumps					
Test for TB					
Does child have any obvious ocular abnormalities?					
Does vision seem to be adequate in each eye?					
Date of most recent examination of child:					
Physician's Signature:				**Date:**	

SOCIAL SERVICE NEEDS ASSESSMENT

Site: ____ Class #: ________________

Our staff is available to provide assistance to children and families toward improving the quality of family life. Our role is that of an advocate to you in the various areas where concerns may arise and assistance is needed. THE STAFF IS IN NO WAY CONNECTED WITH THE DEPARTMENT OF PUBLIC SOCIAL SERVICES other than in providing assistance to you as determined by your needs. All information between us is CONFIDENTIAL.

To help staff facilitate this process, please complete the Needs Assessment by checking the areas below in which you may need assistance or would like more information. There will be follow-up information and referral services available to you.

Information on the following areas is available. Please check your area(s) of concern.

Needs of enrolled child/other children _____
Child abuse/Negligence/Spousal abuse _____
Education needs _____
Financial counseling _____
Emergency assistance/Crisis intervention _____
Family relations _____
Legal Aid _____
Employment needs _____
Housing _____
Immigration _____
Budgeting _____
Translation _____
Food stamps _____
DPSS Concerns _____
Social Security/SSI _____
Nutrition information _____
More information about services _____
Other problem(s) _____

Specify

____

____

____________________	____________________	____________________
Child's Name	Date of Birth	Telephone Number
Parent or Guardian Name	Address	
City	Zip Code	Date

SOCIAL SERVICE NEEDS ASSESSMENT

FOLLOW-UP

1. Date: ______________________________ Outcome: ______________________________

2. Date: ______________________________ Outcome: ______________________________

3. Date: ______________________________ Outcome: ______________________________

4. Date: ______________________________ Outcome: ______________________________

5. Date: ______________________________ Outcome: ______________________________

Please complete the top portion **ONLY** of Training Verification Form and take to CalWorks Office to be completed and stamped.

After your form is stamped return it back with your application

CALIFORNIA DEPARTMENT OF EDUCATION
CHILD DEVELOPMENT DIVISION
Form CD-9605, (Revised: 02/04)

NOTE: When applicable, this form is to be completed and used with form, CD-9600.

TRAINING VERIFICATION -
PARENT OR CARETAKER ATTENDING
SCHOOL OR RECEIVING TRAINING

Please print or type information.

DATE

INSTRUCTIONS

Determining eligibility for child development services requires that the parent or caretaker do the following:

1. Complete all information requested.
2. When completed, take this form to the school or organization where the training or education will be received.
3. Request that the registrar (or his/her designee) verify the training plan as described by signing and stamping this form.
4. Return this form within two weeks to the agency that will provide the child development services.

AGENCY

PARENT OR CARETAKER'S NAME (last, first, middle)

TELEPHONE NO.
(   )

STREET ADDRESS

CITY

ZIP CODE

TRAINING/EDUCATION INFORMATION

NAME OF SCHOOL OR ORGANIZATION WHERE TRAINING/EDUCATION IS RECEIVED

TELEPHONE NO.
(   )

STREET ADDRESS

CITY

ZIP CODE

DATE THIS TERM BEGAN

DATE THIS TERM ENDS

ANTICIPATED COMPLETION DATE FOR TRAINING/EDUCATION

PROFESSIONAL OR VOCATIONAL GOALS

CLASS SCHEDULE (if applicable)

	DAY	TIME	ROOM NO.	COURSE NAME	UNITS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

SIGNATURE OF PARENT OR CARETAKER

DATE

SIGNATURE AND STAMP OF REGISTRAR OF SCHOOL/ORGANIZATION

DATE