VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

YOUR ACTION IS REQUIRED

Mandatory Health & School Forms

Due no later than **Thursday, May 25, 2023**

Dear New & Returning ECC Families:

We are already very busy preparing for the 2023-2024 School Year!

California State Law mandates that all enrolled school children must complete **REQUIRED Health Forms** each year. Please take time to complete the necessary Health & School Forms included and **return the FULL packet no later than Thursday, May 25th.** We ask that you wait to submit all forms at once, as we will not accept partial packets. We appreciate your understanding.

Once all your forms have been submitted, you will receive a confirmation email with an *optional 2023-2024* "Friend Request" form to complete. Please be in touch with ECC Enrollment Coordinator, Aimee Sesar, with any questions at all.

With Thanks,

Your ECC Administrative Team

Facilities # 191-2021-52

VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

Student Intake Form

To Be Completed by Parent/Guardian

Child's Name: _____ Parent's Name: _____

Child's Birthday: _____ Child's Age: _____ Today's Date: _____

1. Please list any concerns about your child's learning, development, and behavior.

2. Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A Little Comments:

3. Do you have any concerns about how your child understands what you say?

Circle one: No Yes A Little Comments:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A Little Comments:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A Little Comments:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A Little Comments:

7. **Do you have any concerns about how your child gets along with others?**

Circle one: No Yes A Little Comments:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A Little Comments:

9. Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A Little Comments:

10. Please list any other concerns.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

VALLEY BETH SHALOM ECC EARLY CHILDHOOD CENTER

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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)

_____. This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ 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:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION 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)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS 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: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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
☐ 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'S 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'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

VALLEY BETH SHALOM

ECC

EARLY CHILDHOOD CENTER

CONSENT FOR EMERGENCY MEDICAL TREATMENT

(to be completed by parent or guardian per State of California Department of Social Services LIC627)

Student Name **Date of Birth**

Parent/Guardian Printed Name(s)

As the parent or legal guardian of _____,
I authorize any adult acting on behalf of **VALLEY BETH SHALOM EARLY CHILDHOOD CENTER** and consent to all necessary emergency care for my child to be rendered by a duly licensed physician, surgeon, dentist and/or other medical professional. This care may be given under whatever conditions are necessary to preserve the health and safety of my child. I further agree to pay all charges for that care and/or treatment. It is understood that if time and circumstances reasonably permit, **VALLEY BETH SHALOM EARLY CHILDHOOD CENTER** personnel will try, but are not required, to communicate with me prior to such treatment.

Parent/Guardian Signatures **Relationship** **Date**

Parent/Guardian Signatures **Relationship** **Date**

Out of State Emergency Contact:

Name **Phone#** **Email** **City/State** **Date**

Insurance Information

Name **Number**

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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

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: Department of Social Services-Childcare Licensing Division

   Licensing Office Address: 300 North Continental Blvd. #290A, El Segundo, CA 90245

   Licensing Office Telephone #: 424-301-3078

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.

_____
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

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:

Department of Social Services, Childcare Licensing Division

NAME

Marina Pilossian

ADDRESS

300 North Continental Blvd #290-A

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
El Segundo	90245	424-301-3060

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)	(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)

VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

FOOD ALLERGY ACTION PLAN

Complete if your child has a food allergy. This form must be signed by a licensed physician.

Attach Child's Photo

Name of Child: **DOB:**

Food Allergy:

Peanuts_____

Tree Nuts (please specify which tree nuts)_____

Eggs_____

Gluten_____

Soy_____

Fish/Shellfish_____

All dairy_____

Other_____

Symptoms: _____

Epipen Needed for Allergy?

Yes_____ (If yes, please also fill out the Anaphylaxis Form)

No_____

Treatment for Allergy:_____

Additional Information: _____

Parent/Guardian Signature:_____

Physician Name: _____

Physician Address/Phone Number:_____

Physician Signature:_____

PLEASE BRING TWO UNEXPIRED EPIPENS (ONE FULL PACK) IN THE ORIGINAL BOX. One EpiPen will be in the main office and the other will be in the classroom.

VALLEY BETH SHALOM ECC EARLY CHILDHOOD CENTER

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Attach child's photo

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above

Sunscreen Authorization Form

I, _____, give Valley Beth Shalom Early Childhood Center Staff permission to reapply sunscreen on my child _____.

I will keep a LABELED bottle of sunscreen in a ziplock bag with my child's name and a copy of this authorization form in his/her cubbie/backpack.

Sign Here: _____

Thank you!

VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

FAMILY HANDBOOK SIGNATURE FORM

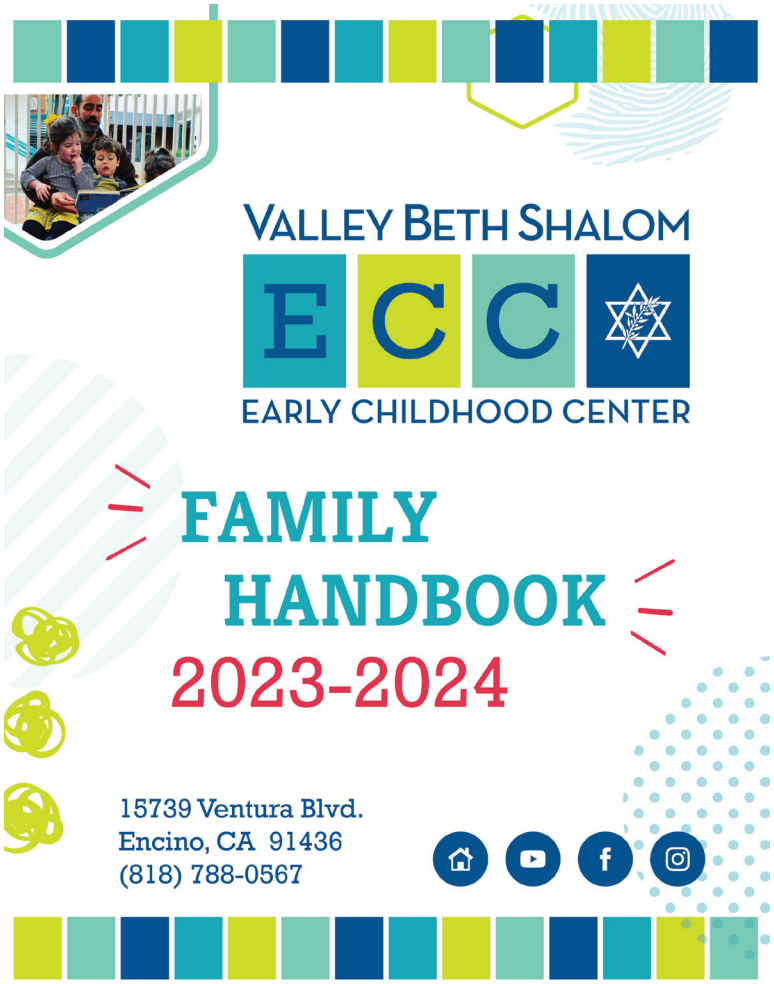
I have read and agreed to the information in the VBS ECC Family Handbook 2023-2024

STUDENT NAME _____

PARENT OR GUARDIAN NAME _____

PARENT OR GUARDIAN SIGNATURE _____

DATE _____



VALLEY BETH SHALOM
ECC
EARLY CHILDHOOD CENTER

VBS ECC | 818-788-0567 | vbs.org/ecc

15739 Ventura Blvd., Encino CA 91436

FACILITY # 191-2021-52

Updated March 2023

Major Dates Calendar 2023-24

august 2023

30	Acorns & Seedlings Parent Orientation • 7:30–9pm	

september

4	Labor Day	**ECC & ITFC Closed**
5	Classroom Visits	
6	First Day of School – Kids Club Begins	
9	PO Welcome Back Tot Shabbat • 9:15am	
15	Erev Rosh Hashanah	**ECC & ITFC Closed**
18	ITFC Classes Begin	
18	Fall Enrichment Classes Begin	
25	Yom Kippur	**ECC & ITFC Closed**
27	ECC Back to School Night • 7:30pm	**No Afternoon Kids Club**

october

3	Seedlings in the Sukkah Family Event • 5pm	
16	Staff Professional Development Day	**ECC & ITFC Closed**
21	Oaks Tot Shabbat • 9:15am	
30	Parent Teacher Conferences	**ECC Closed**
31	Parent Teacher Conferences	**ECC Closed**

november

10	Veteran's Day	**ECC & ITFC Closed**
18	Sprigs Tot Shabbat • 9:15am	
22-24	Thanksgiving Break	**ECC & ITFC Closed**

december

16	Sprouts Tot Shabbat • 9:15am	
22	ECC Staff Professional Development	**ECC & ITFC Closed**
12/25-1/5	Winter Break	**ECC & ITFC Closed**
26-29	ECC Winter Mini Camp	

january 2024

1	New Years Day Observed	**ECC & ITFC Closed**
2-5	ECC Winter Mini Camp	
8	School Resumes	
15	MLK Day	**ECC & ITFC Closed**
20	Seedlings Tot Shabbat • 9:15am	
24	Sprigs Tu B'Shevat Family Event • 9am	

february

2	Acorns Family Challah Bake & Shabbat • 9am	
10	VBS Schools Gala	
19	Presidents' Day	**ECC & ITFC Closed**

march

2	ECC Family Havdalah • 5pm	
4	Staff Professional Development Day	**ECC & ITFC Closed**
5	ECC Parent-Teacher Conferences	**ECC Closed**
6	ECC Parent-Teacher Conferences	**ECC Closed**
21	Sprouts Family Purim Event • 9am	

april

6	Acorns Tot Shabbat • 9:15am	
4/22-5/3	Spring Break	**ECC & ITFC Closed**
25-26	ECC Spring Mini Camp	

may

1-3	ECC Spring Mini Camp	
6	School Resumes	
10-12	VBS Family Camp	
16	ECC Open House & Art Walk • 7:30–9pm Dismissal: 12:30pm for Oaks, 1pm for Acorns, Seedlings, Sprouts and Sprigs	**Early Dismissal • No Afternoon Kids Club**
27	Memorial Day	**ECC & ITFC Closed**

june

1	ITFC & New Families Tot Shabbat • 9:15am	
5	Last Day of School Dismissal: 12:30pm for Oaks, 1pm for Acorns, Seedlings, Sprouts and Sprigs	**Early Dismissal • No Afternoon Kids Club**
6	Pre-K Oaks Siyyum • 10am TK Oaks Siyyum • 2pm	

For updated information visit vbs.org/ecc, see our Friday Weekly ECC Newsletter e-blast emails, or call the ECC office at 818.788.0567.