PLEASE BRING:
- Birth Certificates of ALL your children
- Proof of Residence (PG&E Bill, Phone Bill, etc.)
- Last 2 Paycheck Stubs

OFFICE USE ONLY:
Date Received: ____________________
Called for Appointment: Circle: YES NO
Accepted: YES NO

BEARS APPLICATION

PLEASE COMPLETE ALL INFORMATION

Today's Date:________________ Child's name: ________________________________ Sex (M/F) ________

Current Grade Level ________________ School ID #________________________________

What BUSD school does your child currently attend? ________________________________

Have you also enrolled your child in the LEARNS program? ☐ Yes ☐ No

List other children in the home below.

Student Name	Grade	Age	Ethnicity	School	School ID #	Will he/she attend BEARS?

Adults Assuming Responsibility and Care of Dependents:

Parent /Guardian Name A	Phone No.:	Cell No.:
Parent/Guardian Name B	Phone No.:	Cell No.
Street Address:	City:	Zip:
Estimated Gross Monthly Income (before taxes):	Family Size:	
	Adults:	Children:

When will you need your student(s) in the BEARS program? (Check all that apply)

☐ Before School (7am-9am)

☐ Holiday Breaks (Winter 5 days/Spring 4 days)

☐ After School (________pm - ________pm)

☐ Summer

How many days per week will you need services?

☐ Monday through Friday

☐ Less than five days per week (check all that apply)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

In order to enroll in the BEARS program, the California Department of Education's Child Development Division requires that there first be a need for services. All adults in the household MUST meet one of the following requirements below. Please check what applies:

☐ Child is under Protective Services
☐ Parent(s) are employed or self-employed
☐ In School
☐ Parent is seeking employment
☐ Parent has a disability
☐ Family is homeless

Additional Information. Please check all that applies:

☐ English is your second language
☐ Cal WORKS Recipient:
Case No.: ________________
☐ SSI Recipient
☐ Child is in IEP special program

BEARS

Parent - Application Checklist

Date: _______________ Child's Name___________________________ BUSD School________________________

A. **Application Form**

B. **Need:**

Please provide **ONE** of the following six documents **per parent** in the home to verify a need for care:

1) **Working** parents need to provide **both**:
   - _____ Income Verification (tax records or 2 consecutive original check stubs) **and**
   - _____ A completed and signed Employee Verification Form (Attachment A) **or**
   - _____ A completed and signed Declaration of Self Employment Form

2) Parents attending **school or receiving training** need to provide:
   - _____ Current class schedule

3) Parents who are **medically incapacitated** need to provide:
   - _____ A completed and signed Statement of Parental Incapacity Form (Attachment C)

4) Parents who are **homeless** need to provide:
   - _____ A completed and signed Student Residency Affidavit (Attachment D) **and**

5) Parents with children enrolled in **Child Protective Services** need to provide:
   - _____ A completed and signed letter from a social worker declaring that child care would be in the best interest of the child.

C. **Birth Certificates:**

Please provide copies of birth certificates for all of the dependents in the household - **Including children who are not planning to attend.**

D. **Residency:**

Please provide a copy of **ONE** of the following to confirm residency within the state of California:
- _____ Bill (PGE, EBMUD, telephone bill)
- _____ Rental Agreement
- _____ Bank Statements

E. **Information and Permission Forms:**

Please complete **ALL** of the following documents:
- _____ Emergency and Identification Information (Attachment E)
- _____ Medication Information (Attachment F)
- _____ Field Trip Permission Form (Attachment G)
- _____ Publicity Permission Form (Attachment H)

F. **Single Parents:**

G. Please provide the following:
- _____ Declaration: Single Parent
- _____ Any Legal Document of Separation (e.g. divorce papers, etc.)

H. **Other Sources of Income:**

I. Please provide the following documentation, if applicable:
- _____ Child Support
- _____ Public Assistance: Cal WORKS, Cal Fresh, etc.
- _____ SSI
- _____ Other

J. **After all forms are completed and signed, please send to ATTENTION BUSD BEARS: 1939 Ward Street, Berkeley, CA 94703,**

K. **Please call 644-8938 or email** sheritamiller@berkeley.net to schedule an appointment with the BEARS office staff to complete the registration forms and to review the program policies. During this meeting, you will be informed if your application is **accepted or placed on the waiting list.**

Attachment C

CALIFORNIA DEPARTMENT OF EDUCATION
Child Development Division
Form CD-9606, (Rev. June 2008)

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

STATEMENT OF PARENTAL INCAPACITY

Please print or type information.

PART I – To be completed by the authorized agency representative and the incapacitated parent.
By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized child care and development services, I authorize and request the health professional named in Part II to release the information requested to the agency identified below. I further authorize the health professional to discuss this Statement of Incapacity with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.

NAME OF PARENT/CARETAKER	SIGNATURE OF PARENT/CARETAKER	DATE

FIRST NAME AND AGE OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:

1.	2.	3.	4.

AGENCY	AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	TELEPHONE NUMBER
		( )

ADDRESS	CITY	ZIP CODE

PART II – To be completed by the licensed health professional.
For the family to be eligible to receive child care and development services under the category of incapacity, the California law requires verification, at least annually, of the physical or mental incapacity of the parent or caretaker that renders the person incapable of caring for or supervising the family's child(ren) without assistance. *(See California Code of Regulations, Title 5, §18088.)* Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.

PATIENT ____________________ HAS

a ☐ physical condition or

a ☐ mental health condition

that prevents him or her from providing care or supervision for the child(ren) listed above for at least part of the day.

Please indicate the time in a day and the days of the week, not to exceed 50 hours in a week, that the parent is unable to care for or supervise the child(ren).

Child care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
End Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm

PROBABLY DATES OF INCAPACITY
From: To:

If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours ☐ and days of the week (M, T, W, T, F, S, S) that services are needed.

If the parent has a physical/medical condition, please identify the extent to which the parent is incapable of providing care and supervision.

Please sign and submit this form to the agency listed in Part I within 15 days of receipt of this form.

NAME OF LICENSED HEALTH PROFESSIONAL	LICENSE TYPE	LICENSE NUMBER

SIGNATURE OF LICENSED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER
		( )

MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY

ADDRESS	CITY	STATE	ZIP CODE

State Department of Education
Child Development Division
CD-9607 (Rev 09/05)

Attachment E

To be completed by parent or guardian and updated at recertification and as changes occurs.

Emergency and Identification Information

I. Family Information

Child's name (Last, First, Middle): ______________________ Birth Date: __________

Mother's name: ______________________

Father's name: ______________________

Child's Address: ______________________ Phone: __________

Mother's business address: ______________________ Phone: __________

Father's business address: ______________________ Phone: __________

II. Names of Persons Authorized to Take Child from the Facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

Name	Telephone	Relationship

III. Additional Persons Who May Be Called in an Emergency to Take Child from the Facility

Name	Address	Telephone	Relationship

IV. Physician to Be Called in an Emergency

Name ______________________ Telephone __________

Address ______________________

V. Medi-Cal Number ______________________ **Medical Insurance** __________

Insurance Number ______________________

VI. Allergies or Other Medical Limitations ______________________

____

VII. Permission for Medical Treatment Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

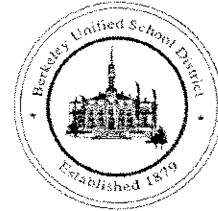
In case of an accident or an emergency, I authorize a staff member of the child development agency to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.

Signature ______________________ Date __________
Parent or Guardian

Attachment F

Berkeley Unified School District

OFFICE OF EXTENDED LEARNING PROGRAMS
1939 Ward Street, Berkeley, California 94704
Phone: (510) 644-7770 Email: zacharypless@berkeley.net



Zachary Pless
Program Supervisor

Dear Parent or Guardian:

Before medication can be given to your child at school, a written statement from your physician is required indicating the name of the medication, the method, the amount to be given, and the time it is to be given. This statement needs to be brought in with the medication.

Thank you for your cooperation.

Sincerely,

Zachary Pless
Program Supervisor of Extended Learning

Health Form #20

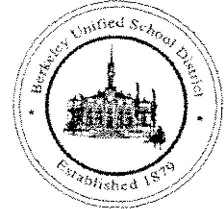
I understand the above policy and will comply with it when my child needs to have medication administered at school.

______________________	______________________	__________
Child's Name	Parent or Guardian Signature	Date

Berkeley Unified School District

OFFICE OF EXTENDED LEARNING PROGRAMS
1939 Ward Street, Berkeley, California 94704
Phone: (510) 644-7770 Email: zacharypless@berkeley.net

Attachment G



FIELD TRIP PERMISSION

BEARS Summer Program

My child ______________________________, may go on short walking trips, bus trips, and trips utilizing other forms of public transportation as planned by the teacher for the duration that he/she is re-enrolled in the BEARS Program.

I, hereby release, and discharge the Berkeley Unified School District, its officers, employees, agents servants (herein collectively referred as "District") from all liability arising out of or in connection with the above described field trip. For the purposes of this statement liability means all claims, demands losses, causes of action, suites, or judgments of any and every kind that I, my child, my heirs, executors, administrators or as assignees may have against the District because of any loss or damage to property that occurs during the above described field trips.

In the event of any illness or injury, I here by consent to whatever x-ray, examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for the safety and welfare of my child.

______________________________ ____________________
Signature of Parent of Guardian Date

______________________________ ____________________
Address Phone

______________________________ ____________________
Health Insurance Plan Policy Number

In the event of illness or accident from above please contact:

____
Name Address Phone

<u>If there are any special medical concern</u>? If yes, please complete the back of this form.

Thank you

Special Medical Concerns/Restrictions:

Special Diet:

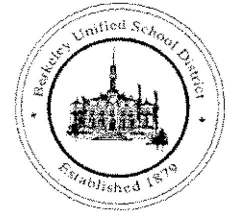
Strenuous Activity:

Additional Special Instructions:

Attachment H

Berkeley Unified School District

OFFICE OF EXTENDED LEARNING PROGRAMS
1939 Ward Street, Berkeley, California 94704
Phone: (510) 644-7770 Email: zacharypless@berkeley.net



PARENT/GUARDIAN PERMISSION SLIP FOR PUBLICITY - PROMOTION

Dear Parent or Guardian:

Your child's class or a portion thereof may be interviewed, photographed, filmed, taped or recorded for school related television or radio programs or articles in newspapers and other publications of interest to students, their parents and the public. In this connection, we may wish to also use your child's name, grade and name of the school. No compensations will be made to you or your child.

In addition, we may use photographs or videotape of class projects, concerts or theatrical productions on our Internet World Wide Web page, without attributing any names to the faces.

Please read the bottom portions of this letter very carefully and check those boxes which express your desires. This will be kept in your child's folder for the duration of his/her enrollment in BEARS Program. If you should change your mind about any item you have checked, please notify the BEARS Registration Office immediately.

Sincerely,

Zachary Pless
Program Supervisor

___ I approve use of photographs and videos of my child for the purposes listed above.

___ I do not want photographs or videos of my child used on the INTERNET.

___ I do not want any photographs or videos of my child used for any reason.

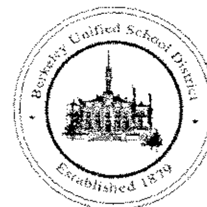
____
Student's Name (please print)

____
Signature of Parent or Guardian Date

Revised 03/2011

Berkeley Unified School District

BEARS Office at
King Child Development Center
1939 Ward Street, Berkeley, CA 94703
Phone: (510) 644-8938
FAX: (510) 644-7711



Zachary Pless
Extended Learning
Program Supervisor

DECLARATION
SINGLE PARENT

I declare under Penalty of Perjury that I am a single parent/ guardian of

____

(name of child)

and that my spouse does not reside in my home. I also state that I am sole financial supporter of my child(ren).

I understand that if my family status or income changes, I am obligated to inform the office immediately, which may affect my eligibility and I will be liable for reimbursing Berkeley Unified School District for any program fees incurred.

______________________________ ____________________

Parent Signature **Date**