Tracy Unified School District

School Readiness Preschool Programs

Enrollment Packet

Preschool Program (3 Hours)

Located at:

NORTH PRESCHOOL #393614190

2875 Holly Drive, Portable 1 Tracy, CA 95376

SOUTH WEST PARK PRESCHOOL #393605949

500 West Mount Diablo Avenue Tracy, CA 95376

VILLALOVOZ PRESCHOOL #393621310

1550 Cypress Drive Tracy, CA 95376

School Readiness Preschool Enrollment Office

500 West Mount Diablo Ave., Tracy, CA 209-830-3355

If you have any questions or need any additional information, please contact Marie Martinez, Preschool Enrollment Secretary, at 209-830-3355 or email: **mmartinez@tusd.net**

2022-2023

Dear Parent/Guardian,

Thank you for your interest in TUSD's Preschool Program. You will begin the process of being placed on our waiting list for our Preschool Program by completing the attached forms. We will access our waiting list and contact families based on the eligibility criteria below.

California State Preschool Program (CSPP)

Part-day CSPP Admission Priorities (*EC* 8261, 8235, 8236 and, 8263(b); 5 *CCR* 18106):

a. **First Priority:** Contractors shall give first priority for services to CSPP three- and four-year-old children who are recipients of child protective services, or who have been determined to be neglected, abused, or exploited or at risk thereof. If an agency is unable to enroll a child in this first priority category, the agency shall refer the child's parent or guardian to local resources and referral services so that services for the child can be located.

b. **Second Priority:** (*EC* 8263[b][2]) Contractors shall give second priority for services to eligible CSPP four-year-old children in the following order: 1) Eligible children who were enrolled in CSPP as a three-year-old; 2) Children whose families have the lowest income ranking based on the most recent Schedule of Income Ceiling eligibility table as published by the SSPI at the time of enrollment; 3) When two or more families have the same income ranking, according to the most recent Schedule of Income Ceiling eligibility table, the child with exceptional needs as defined in EC section 8208 shall be admitted first; 4) If there are no families with children with exceptional needs, the family that has been on the waiting list for the longest time shall be admitted first.

c. **Third Priority:** Contractors shall give third priority for services to eligible CSPP three-year old children in the following order: 1) Children whose families have the lowest income ranking based on the most recent Schedule of Income Ceiling eligibility table as published by the SSPI at the time of enrollment; 2) When two or more families have the same income ranking, according to the most recent Schedule of Income Ceiling eligibility table, the child with exceptional needs as defined in EC section 8208 shall be admitted first; 3) If there are no families with children with exceptional needs, the family that has been on the waiting list for the longest time shall be admitted first.

d. After all otherwise eligible children have been enrolled, the contractor may enroll the following children in the order listed: 1) Children from families whose income is no more than 15% above the eligibility income threshold may be enrolled. Children from families enrolled under this exception may not exceed ten percent of the participating CSPP's total contract enrollment. Priority shall be given to four-year-olds before three-year-olds; 2) Children with exceptional needs as defined in EC Section 8208 may be enrolled, regardless of family's income. Children enrolled pursuant to this subsection, shall not count towards the ten percent limitation. Priority shall be given to four-year-olds before three-year-olds; 3) For CSPP sites operating within the attendance boundaries of a qualified FRPM school, the contractor may, enroll CSPP four-year-old children whose families reside within the attendance boundary of the qualified FRPM elementary school without establishing eligibility pursuant to EC sections 8263(a)(1)(A) and (B). These families shall, to the extent possible, be enrolled in income ranking order, lowest to highest.

Please check the schedule of income ceiling below to see if your total countable income qualifies in meeting income eligible criteria. Please include all salaries when calculating your monthly income.

# of Persons in Family	Family's Total Gross Income/Suma de los ingresos de la familia	
# Personas en la Familia	Monthly/Mensuales	Yearly/Anuales
1-2	$ 7,068	$ 84,818
3	$ 8,049	$ 96,590
4	$ 9,342	$112,105
5	$10,837	$130,042
6	$12,332	$147,979
7	$12,612	$151,342
8	$12,892	$154,705
9	$13,172	$158,068
10	$13,453	$161,431
11	$13,733	$164,794
12 or more	$14,013	$168,158

First 5 Preschool Program

To be eligible for our First 5 program, families must meet one or more of the following qualifications or have one of the following:

1. Age eligible 3 or 4-year-old with special needs.
2. Reside within the attendance boundaries of one of the following TUSD schools: Bohn, Central, Freiler, Hirsch, Jacobson, Kelly, McKinley, North, Poet Christian, South West Park, or Villalovoz schools.
3. Dual language household.
4. Seasonal migrant household.
5. Low-income family.
6. Ethnic household.
7. Experiencing homelessness.
8. Enrolled child in the foster care system.

Please complete the interest forms contained in this packet and gather the required documentation listed on the following page that will need to be submitted along with your packet to our School Readiness Enrollment office located at South West Park Elementary School. Please make sure all your documents are complete, you will be turned away if your packet is not complete at the time of your appointment.

If you have any questions about these forms or if you need help completing them, please call our School Readiness Enrollment Clerk at 209-830-3355.

Rocio Garcia
School Readiness Coordinator
Tracy Unified School District

Tracy Unified School District
School Readiness Preschool Programs

REQUIRED DOCUMENTATION FOR ENROLLMENT

A final registration appointment is required to enroll your child in this program. Based on our priority list, you will be contacted for an enrollment appointment. Bring ALL the required documentation with you to your enrollment appointment. ALL forms must be signed and dated. DO NOT mail these forms.

Proof of Residence:

- ☐ One proof of a street address or post office address in California in your name **OR**
- ☐ One proof of a street address of the primary resident if your family is sharing or renting a room & completed TUSD Student Residency Questionnaire affidavit (both sides).
- ☐ Families experiencing homelessness may submit referral from a social services agency or self-declaration of intent to live in California, no evidence required.

Birth Certificates: for **ALL** children under 18 years of age included in the family size.

Up-to-date Immunization Records: ***Must be provided within 30 days of enrollment.***

- ☐ Immunization records (yellow card) for student.

Physical Exam of child: ***Must be provided within 30 days of enrollment.***

- ☐ Physician's Report LIC701 – must be completed by doctor.

Documentation of total family income: showing **ONE MONTH'S** worth of the family's most recent total gross monthly income. Overtime is averaged over a 3-month period & bonuses are averaged over a 12-month period, additional income documentation may be required.

- ☐ **Weekly Pay**: provide 4-5 consecutive payroll stubs.
- ☐ **Bi-Weekly Pay**: provide 2-3 consecutive payroll stubs.
- ☐ **Monthly Pay**: provide 1 payroll stub from the previous month.
- ☐ **Self-Employed**: letter from source of income, copy of most recently signed AND completed business tax returns including Profit & Loss Report along with a statement of current estimated income for tax purposes, or other business records (ledgers/receipts/business logs).
- ☐ **Child Support/Alimony/TANF Payments & verification of any other income; Unemployment/Disability/Workers Compensation/CalWORKs.**

Tracy Unified School District
School Readiness Preschool Programs

Authorization to Release Employment Verification

I give my permission for information regarding my employment to be released to the Tracy Unified School District's Preschool Program to determine child care eligibility for my child/ren. I understand that falsifying any information regarding employment will make me ineligible for preschool services and can result in prosecution by the District Attorney's office.

Employee's Name – Please print _____ Birth date _____

Employee's Signature _____ Date _____

BUSINESS NAME _____ **BUSINESS PHONE #** _____

BUSINESS ADDRESS _____ **CITY / STATE** _____ **ZIP** _____ **FAX PHONE #** _____

OFFICE USE ONLY - EMPLOYER VERIFICATION

Employee's Classification_____First day of Employment_____Last day, if known_____

Gross Monthly Salary $_____ (include tips, overtime and commission)

HOW OFTEN IS EMPLOYEE PAID:

Monthly_____ Weekly _____ Every 2 weeks_____ 2 times per month_____

Work Days:

MON_____ TUE_____ WED_____ THU_____ FRI_____ SAT_____ SUN_____

Hours of Employment: From_____ To_____

I certify that the information regarding his/her employment is accurate.

Employer or Designee Signature/Name _____

Title _____ Date _____

Working Parent	Date Verified	Verified With (name)	Staff Initials
Parent A:			
Parent B:			

Verification notes:

(Please PRINT) **TRACY UNIFIED SCHOOL DISTRICT PRESCHOOL REGISTRATION FORM** (02/22)

SCHOOL READINESS PRESCHOOL PROGRAM

Student's LEGAL Name: (Name as it appears on the Birth Certificate)

_____ Preschool
Last First Middle Grade

Sex: M☐ F☐ _____
Date of Birth

Parent #1/Guardian Name **Relationship**	**Parent #2/Guardian Name** **Relationship**
Parent with whom the child resides	
Parent #1 Home Phone **Cell Phone**	**Parent #2 Home Phone** **Cell Phone**
Parent #1 Email Address	**Parent #2 Email Address**
Parent #1 Work Phone	**Parent #2 Work Phone**
Parent #1 Residence Address, City, Zip Code	**Parent #2 Residence Address (if different from Parent #1)**
Parent #1 Mailing Address (if different from residence)	**Parent #2 Mailing Address (if different from residence)**

Office Use Only

School_____ **Res Sch** _____
Grade Preschool **ID#** _____
Teacher _____ **Rm** _____
District Enrollment Date_____
School Enter Date _____

TRANSPORTATION OF CHILD:
Please list primary adult(s) responsible for drop off and pick up of child from preschool:

1. _____
2. _____

Has your child attended preschool previously? Yes☐ No☐
If yes, where? _____
Has your child attended any TUSD school? Yes☐ No☐
If yes, where? _____

MEDICAL/HEALTH CONCERNS OF THE CHILD:
Does your child have any MEDICAL/HEALTH conditions we should be aware of? ☐ ***Yes*** ☐ ***No***
If yes, please complete appropriate area on EMERGENCY FORM and attach any additional information needed.
Does your child have any food allergies or restrictions? ***If yes, provide details:***_____
Does your child use: ***An EpiPen*** ☐ ***Insulin*** ☐ ***Other:*** _____

HOME LANGUAGE SURVEY

1. Which language did your child learn when he/she first began to talk? _____
2. Which language do you (parents or guardians) most frequently use when speaking with your child? _____
3. Which language does your child most frequently speak at home? _____
4. Which language is most often spoken by the adults in the home? (parents/guardians/grandparents, etc) _____

(OVER)

What Is Your Child's Ethnicity? (Please check one): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

What is your Child's Race? (Please check up to 5 racial categories)

____ African American/Black (600)	____ Cambodian (207)	____ Hawaiian, Native (301)	____ Laotian (206)	____ Vietnamese (204)
____ American Indian/Alaskan Native (100)	____ Chinese (201)	____ Hmong (208)	____ Pacific Islander, Other (399)	____ White (700)
____ Asian Indian (205)	____ Filipino (400)	____ Japanese (202)	____ Samoan (303)	
____ Asian, other (299)	____ Guamanian (302)	____ Korean (203)	____ Tahitian (304)	

Education Level of child's most educated parent: (Mark only **1**)

☐ Not a high school graduate (1) ☐ Some college (3) ☐ Graduate School/Post Graduate training (5) ☐ High school graduate (2) ☐ College graduate (4) ☐ Decline to state or unknown (6)

*** CHILD'S PLACE OF BIRTH INFORMATION:**

* Place of Birth:City _____ State_____ Country _____ *Date your child first entered the United States (if born outside the US):_____ (MM/DD/YYYY)

*Date your child first enrolled in a school in the United States: _____ (MM/DD/YYYY) *Date your child first entered a California School: _____ (MM/DD/YYYY)

HOME OF THE CHILD:

Child resides with: Parent (1)☐ Parent (2)☐ Both Parents (BP)☐ Joint Custody (JC)☐ Guardian (G)☐ Foster Parent (FP)☐ Other (O) _____

Is there any LEGAL or GUARDIANSHIP information about your child we should be aware of? **Yes** ☐ **No** ☐

If divorced/separated, is there joint custody? ***Yes*** ☐ ***No*** ☐ ***If no, who has custody?*** _____

Is there a restraining order in effect? ***Yes*** ☐ ***No*** ☐ ***If yes, please explain:*** _____

Provide copies of applicable LEGAL DOCUMENTS when necessary. Parents must complete the Educational/Medical Rights form for Step-Parents to have rights.

INFORMATION ABOUT THE CHILD:

Has your child been evaluated or are they receiving any Special Education Services? Yes ☐ No ☐

Speech, behavior, development, etc. If yes, please explain: _____

Does your child have an IFSP (Individualized Family Service Plan) or an IEP (Individualized Educational Plan)? Yes ☐ No ☐ *If yes, please provide a copy.*

Do you have any concerns about your child's development? Yes ☐ No ☐ If yes, please explain:_____

_____

NAMES OF OTHER CHILDREN AGE 18 AND UNDER IN THE HOUSEHOLD (BROTHERS, SISTERS.): (Please provide name, relationship, birth date and grade)

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

Name: _____ Relationship: _____ Birth date: _____ Grade: _____

_____ _____ _____ _____

Parent/Guardian Signature Date TUSD School Readiness Preschool Authorized Signature Date

Name of Student _____ Grade _____

SITE USE ONLY
Initial: _____
Date: _____

Student Residency Questionnaire

(One questionnaire required per student)

This form must be completed at the beginning of every school year by all parents/guardians and/or unaccompanied youth. The information provided on this form can assist with identifying students who qualify for services under the McKinney-Vento Act (Transitional Housing).

Parent #1/ Guardian Name: _____ Relationship to Student: _____
Current Residence Address: _____
How long have you been at this location? _____ Phone Number: _____
Parent #2/ Guardian Name: _____ Relationship to Student: _____
Current Residence Address: _____
How long have you been at this location? _____ Phone Number: _____

******Note: If legal custody is split between two parents, in addition to the documents listed below, you will need to attach a certified copy of the court order identifying each parent's respective award of physical custody. You are responsible to immediately inform the school of any changes to the court order. ******

PLEASE LIST ALL OF THE PRESCHOOL AND SCHOOL-AGED CHILDREN LIVING IN YOUR HOME:

Name: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____
Name: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____
Name: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____
Name: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____
Name: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____

Are any of your students in foster placement? ❑ YES ❑ NO
(If you answer YES, please complete a Foster Student Questionnaire for each foster student.)

PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES YOUR CURRENT LIVING SITUATION:

- ☐ Rent/own apartment or home **(IF CHECKED, GO TO STEP A)**
- ☐ Preferred Sharing Home or Long-Term Living Arrangements **(IF CHECKED, GO TO STEP B)**
- ☐ Sharing the housing of other person due to **(CHECK ONE BELOW)**:
  - ☐ Loss of housing, economic hardship or a similar reason such as evicted from home
  - ☐ Living in a motel, hotel, campground, trailer park or similar setting
  - ☐ Living in emergency or transitional such as domestic violence or homeless shelters or in transitional housing
  - ☐ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation
  - ☐ Sleeping in cars, parks, public spaces, abandoned buildings, substandard housing or similar settings
  - ☐ Living with an adult that is not a parent or legal guardian, or living alone without an adult
  - ☐ Political Asylum

A. If you own or rent the property in which you reside, please attach 1 of these items with ***your name (PARENT/GUARDIAN)*** & current address:
   a. Recent copy of mortgage/rental agreement OR San Joaquin County Tax Bill
   b. Recent copy of utility bill (PGE, City of Tracy, etc.)
   c. One other recent bill mailed to you at your address OR Current Driver's License or California ID from the DMV with updated address.

B. If you are sharing a home with another individual or family, please attach 1 of these items with ***their name (PRIMARY RESIDENT)*** and current address and complete a **RESIDENCY AFFIDAVIT** form **in person**:
   a. Recent copy of mortgage/rental agreement OR San Joaquin County Tax Bill
   b. Recent copy of utility bill (PGE, City of Tracy, etc.)
   c. One other recent bill mailed to them at their address OR Current Driver's License or California ID from the DMV with updated address.

If you would like to receive information regarding available resources, please request a Housing Questionnaire to complete.

The address listed above is my primary residence. I agree to notify TUSD immediately if there is any change in the status of my residency. I certify that all the information provided is true and correct. I am aware that District Officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution or other penalties under District, State and Federal Laws.

Parent/Guardian Signature: _____ Date: _____

Student's Name: _____ Birthdate:_____ Grade:_____ Teacher: _____

TRACY UNIFIED SCHOOL DISTRICT EMERGENCY TREATMENT FORM

***Note:* If the information listed below changes at any time during the school year, notify the office immediately!**

The Tracy Unified School District's Emergency Treatment Policy for student injury and illness at school permits school personnel to dial "911", the emergency telephone number. With authorization, emergency medical treatment can be provided. For other than life-sustaining treatment, the medical professionals require the parent/guardians' authorization before emergency treatment can be administered.

In the event of serious injury or illness, school personnel will immediately attempt to notify the parent/guardian. If the parent/guardian cannot be reached, and this form is on file in the school office, the school will be authorized to arrange transportation of the student for emergency medical treatment. This form also authorizes a medical professional on duty to perform emergency treatment.

Please complete this form below and return it immediately to your child's school to be placed on file in the school office. Thank you for your cooperation. ***PLEASE PRINT LEGIBLY***

Parent/Guardian name with **whom child is residing**: _____

Circle if Parent or Guardian
Parent #1/Guardian's Name: _____

Address: _____

House phone # _____Cell # _____ Work # _____

Circle if Parent or Guardian
Parent #2/Guardian's Name: _____

Address: _____

House phone # _____Cell # _____ Work # _____

Does your child have any medical disorders the school/doctor should be aware of before treatment, if YES please describe below. If no, please mark none: ☐ NONE

_____

_____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Doctor's Name: _____Phone: _____

Insurance Company name: _____ Policy/MRN# _____

AUTHORIZATION FOR EMERGENCY TREATMENT AND TRANSPORTATION

I authorize Tracy Unified School District to dial "911" and to arrange emergency transportation to an emergency treatment center or hospital for my child is s/he is seriously injured or ill.

The undersigned has authorized necessary emergency treatment for the patient whose name appears above and that the treatment and procedures will be performed by medical professionals. The undersigned understands that a personal physician is to be selected by, or on behalf of, the patient within 24 hours if hospitalization or further treatment is required, or immediately, if complications arise.

Financial Responsibility: Parents are reminded that financial responsibility including all costs of paramedic, transportation, hospitalization, and any examination, treatment, or x-ray provided shall be the parent/guardian's responsibility should emergency treatment become necessary.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the result that may be obtained. This authorization for emergency treatment and transportation will remain in effect during the time the student is enrolled in a Tracy Unified School District School or program. Authorization is also hereby granted for release to all insurance companies and agencies such information as may be necessary for completion of hospitalization claims.

Parent/Guardian Signature: _____ Date: _____

(Feb 2022/PreK)

Tracy Unified School District
School Readiness Preschool Programs

MEDIA CONSENT AND RELEASE FORM

Tracy Unified School District (TUSD) or First 5 San Joaquin (F5SJ) occasionally takes photos, makes videos, or writes stories about the families being served in the preschool programs. I understand that photographs or videos taken of me or my child and statements made by me or my child while participating in the program may be used in communication materials such as Learning Genie (a parent/teacher engagement app) or school yearbooks. I hereby give TUSD/F5SJ permission to:

- Take my and/or my child's photo.
- Make a video-recording of me and/or my child.
- Use statements made by me and/or my child.

In addition, I give permission to TUSD/F5SJ and its affiliates to use stories, pictures, and/or videos in a variety of ways that may include, but are not limited to: newsletters, brochures, Learning Genie, magazines, social media, and newspapers. I further understand that my name and my child's name will not be published. Images and content may be used without any further notification.

_____
DATE

_____
CHILD'S NAME

_____
PARENT/GUARDIAN'S SIGNATURE

_____
PARENT/GUARDIAN'S PRINTED NAME

_____
WITNESS

*Parent or Guardian **must** sign for children under 18 years of age, this includes teen parents.

FY 2022-2023

FIRST 5 San Joaquin

TRACY UNIFIED SCHOOL DISTRICT
SCHOOL READINESS PRESCHOOL PROGRAM

WALKING FIELD TRIP RELEASE FORM

I give permission for my child to take part in on-campus field trips or walks in the vicinity of the campus that are arranged and supervised by staff. I understand, however, that I will be notified in advance of any off-campus field trips that involve transportation by car or bus and that I will be asked to complete additional parent permission forms for any such field trip.

_____
Child's Name

_____ _____
Parent Signature **Date**

DISTRITO ESCOLAR UNIFICADO DE TRACY
PROGRAMA PREESCOLAR DE PREPARACIÓN ESCOLAR

FORMA DE PERMISO PARA EXCUSIONES A PIE

Doy permiso para que mi hijo/a participe en excursiones o caminatas en el campus o en los alrededores del campus, organizados y supervisados por el personal. Sin embargo, entiendo, que se me notificará con anticipación de cualquier excursión fuera del campus que implique transporte en automóvil o autobús y que se me pedirá que llene formas adicionales de permiso de los padres para cualquier excursión de este tipo.

_____
Nombre del Niño/a

_____ _____
Firma del Padre/tutor **Fecha**

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

TRACY UNIFIED SCHOOL DISTRICT
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME
. THIS CARE MAY BE GIVEN UNDER

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
( )	( )

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

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