



PASADENA UNIFIED SCHOOL DISTRICT  
Early Childhood Education Programs  
2046 N Allen Ave  
Altadena, CA 91001  
(626) 396-5762 ext. 10070

## **REGISTRATION REQUIREMENTS FOR ALL FULL FEE PROGRAMS**

- **BIRTH OR HOSPITAL CERTIFICATE** for the enrolling child
- **CURRENT IMMUNIZATION RECORDS** with a **current TB test or TB screening** for the enrolling child
- **CURRENT PHYSICAL EXAM** (page #6 in packet)
- **PROOF OF ADDRESS** current utility bill or complete lease/rental agreement
- **COPY OF IEP** if applicable
- **\$25.00 FIELD TRIP FEE** (non-refundable) check or money order only. No cash.
- **\$50.00 REGISTRATION FEE** check or money order only. No cash.
- **MONTHLY FEE FOR THE FIRST MONTH** check or money order only.





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**\*\*\*\*\*Important Message for all Parents\*\*\*\*\***

Please note that all families who have a family fee for services being received must pay their fees on the first of each month.

Families enrolled in a Full Day preschool program must pay their fees at the Children's Center in which their child is attending.

**If you are enrolled in a 3 hour preschool program your payment is to be made at:**

**Burbank Center  
2046 N. Allen Ave  
Altadena, CA 91001**

**Personal checks and money orders only.**

**We cannot accept cash.**

**\*\*\*\*\*Mensaje Importante Para Los Padres\*\*\*\*\***

Por favor tomen en cuenta que las familias que tienen una cuota por los servicios recibidos deben de pagar al principio del mes.

Las familias registradas en el programa de todo el día deben de pagar en el centro donde sus niños/niñas están registrados.

**Las familias en el programa pre-escolar de 3 horas deben de pagar en el centro de Burbank.**

**Burbank Center  
2046 N. Allen Ave  
Altadena, CA 91001**

**Solamente aceptamos cheques personales y giros postales.**

**Dinero en efectivo no será aceptado.**





# PASADENA UNIFIED SCHOOL DISTRICT STUDENT REGISTRATION FORM

Please print clearly with black or blue ink.

Teacher's Name: \_\_\_\_\_  
 Room #: \_\_\_\_\_ Date input: \_\_\_\_\_ Stu# \_\_\_\_\_

## STUDENT DATA

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_  /   
 Male / Female

Current Grade \_\_\_\_\_ Birthdate (mm/dd/yyyy) \_\_\_\_\_ Current Age \_\_\_\_\_ AKA/Nickname \_\_\_\_\_

MAILING Address (Street and Apt. #) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

RESIDENCE Address (Street and Apt. #) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth City \_\_\_\_\_ Birth State/Province \_\_\_\_\_ Birth Country \_\_\_\_\_ Home Phone Number \_\_\_\_\_

If born outside of the United States, when did your child first enter the United States? (mm/yyyy) \_\_\_\_\_

## FAMILY INFORMATION

Student Lives With:  Both Parents  Mother only  Father and Stepmother  Foster Parents  
 Legal Guardian(s)  Father only  Mother and Stepfather  Other: \_\_\_\_\_

**Mother / Legal Guardian Name:** \_\_\_\_\_  
 Primary Phone Number \_\_\_\_\_ Secondary Phone Number \_\_\_\_\_  
 This is my  Cell  Home  Work  Other

Last Name, First Name \_\_\_\_\_

**Father / Legal Guardian Name:** \_\_\_\_\_  
 Primary Phone Number \_\_\_\_\_ Secondary Phone Number \_\_\_\_\_  
 This is my  Cell  Home  Work  Other

Last Name, First Name \_\_\_\_\_

Primary Contact (please check one only):  Mother / Legal Guardian  Father / Legal Guardian

Parent's Email Address (one only please): \_\_\_\_\_

**Family Living In:**

Permanent Housing  Hotel/Motel  Licensed Children's Institution  
 Foster Family or Kinship Placement  Temporarily Unsheltered  Other: \_\_\_\_\_  
 Temporary Shared Housing  Temporary Shelter in Emergency or Foster Care

Have you or any members of your immediate family worked in agriculture, fishing, or food processing on a temporary basis in the last three years?  Yes  No

## STATE MANDATED INFORMATION

**What is your child's ETHNICITY? (check one)**  **Hispanic or Latino**  
*A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*  
 **Not Hispanic or Latino**

In addition, what is your child's RACE? Please check AT LEAST ONE and up to five racial categories. The first part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer by making a checkmark in one or more boxes next to what you consider your child's race(s) to be.

American Indian or Alaska Native  Cambodian  Hmong  Native Hawaiian/Pacific Islander  Vietnamese  
 Armenian  Chinese  Japanese  Other Asian  White  
 Asian Indian  Filipino  Korean  Samoan  
 Black or African American  Guamanian  Laotian  Tahitian

**Parent/Guardian Education Level** (please check only the HIGHEST education level completed by either parent/guardian):

Graduate school/Post Graduate training  Some college (includes AA degree)  Not a high school graduate  
 College graduate  High school graduate

Did your child attend pre-school?  Yes  No If yes, which pre-school? \_\_\_\_\_

When did your child first enroll in a United States K-12 school? (mm/dd/yyyy) \_\_\_\_\_ Grade \_\_\_\_\_

When did your child first enroll in a California K-12 school? (mm/dd/yyyy) \_\_\_\_\_ Grade \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>		<b>Enrolling School:</b> _____	<b>Today's Date:</b> _____	<b>Enrollment Date:</b> _____
<b>Verification of Legal Name and Birth date by:</b>		<b>Medical:</b>		<b>Student's Perm. ID #:</b> _____
<input type="checkbox"/> Birth Cert	<input type="checkbox"/> Hospital Cert	<input type="checkbox"/> Passport/Visa	Immunizations completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exempt	<b>Form Processed By:</b> _____
<input type="checkbox"/> Baptism	<input type="checkbox"/> School Records	<input type="checkbox"/> Affidavit	Verified by (name): _____	



PASADENA UNIFIED SCHOOL DISTRICT – STUDENT REGISTRATION FORM – PAGE 2

STUDENT LAST NAME \_\_\_\_\_ STUDENT FIRST NAME \_\_\_\_\_ PERM.ID# \_\_\_\_\_

HOME LANGUAGE SURVEY

What was the first language your child learned? \_\_\_\_\_

What language does your child use most frequently at home? \_\_\_\_\_

What language do you use most frequently to speak to your child? \_\_\_\_\_

If possible, in what language would you prefer to receive school communications? \_\_\_\_\_

OTHER CHILDREN LIVING IN THE HOME

\_\_\_\_\_  
Last Name, First Name, Middle Name Relationship Birthdate Current School Grade

\_\_\_\_\_  
Last Name, First Name, Middle Name Relationship Birthdate Current School Grade

\_\_\_\_\_  
Last Name, First Name, Middle Name Relationship Birthdate Current School Grade

\_\_\_\_\_  
Last Name, First Name, Middle Name Relationship Birthdate Current School Grade

ACADEMIC HISTORY

Has your child ever attended a Pasadena Unified School (including Pre-K or summer school)?  Yes  No

My child [disclosure of information is REQUIRED by California Education Code 48915.1(b)]:

is **not** under an expulsion order or recommended for expulsion from another school district.

is currently under an expulsion order or has been recommended for expulsion from \_\_\_\_\_ School District.

PREVIOUS SCHOOLS ATTENDED - PLEASE INCLUDE ALL PREVIOUS SCHOOLS

\_\_\_\_\_  
Name of Last School School District City State / Country Grade(s)

\_\_\_\_\_  
Name of Last School School District City State / Country Grade(s)

\_\_\_\_\_  
Name of Last School School District City State / Country Grade(s)

SCHOOL AND SPECIALIZED EDUCATION PROGRAMS

My child is receiving or has received services in (please check all that apply):

- 504 Plan  Gifted and Talented Education (GATE)  Title I
- Alternative/Bilingual Program (waiver)  Special Education/IEP, please specify: \_\_\_\_\_  Other, please specify: \_\_\_\_\_
- English Language Development  Speech/Language Services (IEP)  My child has never been enrolled in any of these programs.

EMERGENCY INFORMATION

Doctor's Name / Address / Telephone: \_\_\_\_\_

Name of Other Relative: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Telephone: \_\_\_\_\_

AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION - FERPA PRIVACY AUTHORIZATION

I give consent for Pasadena Unified School District to submit information to the LEA billing option vendor, Paradigm, regarding school health services provided to my child for the purpose of receiving federal reimbursement. This reimbursement helps to defray the cost of providing these health services. All information is kept confidential.

Parent/Guardian Initials \_\_\_\_\_

OTHER HEALTH COVERAGE INQUIRIES

Many private insurance companies do not pay for school health services, but school districts must attempt to bill for those services. If your child has private health insurance (not Medi-Cal) do you give permission to Pasadena Unified School District to bill that insurance? If no, please note that school health services will continue to be provided and parents will never be billed. If yes, please fill out the following:  Yes  No

Private Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone# \_\_\_\_\_

Students will only be released to those named on this form. No treatment will be given other than in a serious emergency without contacting parent/guardian. My signature certifies that all information is accurate. In order to keep my child safe, I will report any changes of address, telephone, or emergency information to the school site within five days.

SIGNATURE OF PARENT/ LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



## 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

NAME

Community Care Licensing

ADDRESS

1000 Corporate Center Drive #200B M.S. 29-15

CITY

Monterey Park, CA

ZIP CODE

91754

AREA CODE/TELEPHONE NUMBER

(323) 981-3351

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)



## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### 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 Community Care Licensing

Licensing Office Address: 1000 Corporate Center Dr, #200B MS 29-15, Monterey Park 91754

Licensing Office Telephone #: (323) 981-3351

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](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### 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](http://www.meganslaw.ca.gov)*



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

DATE OF ADMISSION	DATE LEFT
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# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

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

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

HOME PHONE  
( )

WORK PHONE  
( )



**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*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**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?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*
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PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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



# 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: \_\_\_\_\_

other: \_\_\_\_\_

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: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

Date This Form Completed: \_\_\_\_\_

Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

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**RISK FACTORS FOR TB IN CHILDREN:**

- \* Have a family member or contacts with a history of confirmed or suspected TB.
- \* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- \* Live in out-of-home placements.
- \* Have, or are suspected to have, HIV infection.
- \* Live with an adult with HIV seropositivity.
- \* Live with an adult who has been incarcerated in the last five years.
- \* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- \* Have abnormalities on chest X-ray suggestive of TB.
- \* Have clinical evidence of TB.

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Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

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# PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR CHILD CARE OR PRESCHOOL



Requirements by Age at Entry and Later (Follow-up is required at every age checkpoint after entry.)

Vaccine	2–3 Months	4–5 Months	6–14 Months	15–17 Months	18 Months–5 Years
Polio (OPV or IPV)	1 dose	2 doses	2 doses	3 doses	3 doses
Diphtheria, Tetanus, and Pertussis (DTaP or DTP)	1 dose	2 doses	3 doses	3 doses	4 doses
Measles, Mumps, and Rubella (MMR)				1 dose on or after the 1st birthday	1 dose on or after the 1st birthday
Hib	1 dose	2 doses	2 doses	1 dose on or after the 1st birthday	1 dose on or after the 1st birthday (only required for children less than 4 years, 6 months.)
Hepatitis B (Hep B or HBV)	1 dose	2 doses	2 doses	2 doses	3 doses
Varicella (chickenpox, VAR or VZV)					1 dose

## WHY YOUR CHILD NEEDS SHOTS:

The California School Immunization Law requires that children be up-to-date on their immunizations (shots) to attend a child care, day nursery, nursery school, family day care home, or development center.

Diseases like measles spread quickly, so children need to be protected before they enter. Staff will check your child's Immunization Records before they start and later, at ages listed above.

## THE LAW:

Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

## WHAT YOU WILL NEED FOR ADMISSION:

To attend a child-care facility, your child's Immunization Record must show the date for each required shot above. If you do not

have an Immunization Record, or your child has not received all required shots, call your doctor now for an appointment.

If a licensed physician determines a vaccine should not be given to your child because of medical reasons, submit a written statement from the physician for a **medical exemption** for the missing shot(s), including the duration of the medical exemption.

A personal beliefs exemption is no longer an option for entry into child care; however a valid personal beliefs exemption filed with a child-care facility before January 1, 2016 is valid until entry into the next grade span (transitional kindergarten through 6th grade) and may be transferred between child-care facilities in California. For complete details, visit [ShotsforSchool.org](http://ShotsforSchool.org).

You must also submit an immunization record for all required shots not exempted.

Questions? Visit [ShotsForSchool.org](http://ShotsForSchool.org) or contact your local health department ([bit.do/immunization](http://bit.do/immunization)).





# PASADENA UNIFIED SCHOOL DISTRICT

## Early Childhood Education Programs

REE HUDSON  
Director

JULIE REYNOSO  
Asst. Superintendent, Elementary Schools

Dear parents,

If you are interested in volunteering at any of our preschools, according to the State of California Health and Human Services Agency, Department of Social Services, Community Care Licensing department, effective September 1<sup>st</sup>, 2016, we must implement SB 792. You must also provide proof of a **TB (tuberculosis) test/screening** completed within the last year.

**1596.7995.**

(a)(1) Commencing September 1<sup>st</sup>, 2016, a person **shall not be employed or volunteer at a daycare center if he or she has not been immunized against,**

- 1. Influenza, 2. Pertussis, and 3. Measles.**

Each employee and volunteer shall receive an influenza vaccination (flu shot) between August 1<sup>st</sup> and December 1<sup>st</sup> of each year.

(2) If a person meets all other requirements for employment or volunteering, as applicable, but needs additional time to obtain and provide his or her immunization records, the person may be employed or volunteer conditionally for a **maximum of 30 days upon signing and submitting a written statement attesting that he or she has been immunized as required.**

(b) A person is **exempt** from the requirements of this section only under any of the following circumstances:

- (1) The person submits a written statement from a licensed physician declaring that because of the person's physical condition or medical circumstances, immunization is not safe.*
- (2) The person submits a written statement from a licensed physician providing that the person has evidence of current immunity to the diseases described in subdivision (a).*
- (3) The person submits a written declaration that he or she has declined the influenza vaccination. This exemption applies only to the influenza vaccine.*
- (4) The person was hired after December 1<sup>st</sup> of the previous year and before August 1<sup>st</sup> of the current year. This exemption applies only to the influenza vaccine during the first year of employment or volunteering.*

(c) The day care center shall maintain documentation of the required immunizations or exemptions from immunization, as set forth in this section, in the person's personnel record that is maintained by the day care center.

(d) Section 1596.890 does not apply to a violation of this section.

(e) For purposes of this section, "volunteer" means any non-employee who provides care and supervision to children in care.

**I have received the child care employee and volunteer immunization and tuberculosis requirements.**

**Please note: Signing this form does not clear you as a volunteer. Please register with the main office.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
School

\_\_\_\_\_  
Date





**PASADENA UNIFIED SCHOOL DISTRICT**  
OFFICE OF THE SUPERINTENDENT

Dear Parent/Guardian:

The Pasadena Unified School District ("District") may produce or participate in video, motion picture, audio recording, web page, or still photograph productions, broadcasting, and/or publication which may involve the use of students' names, likenesses or voices. Such productions will be used for non-commercial educational, exhibition, promotional, advertising, or other purposes by the District and will not be sold to other school systems or education professionals. Such productions may be copied, copyrighted, edited, and distributed by the District in the manner described above.

By **not** signing and returning this form to your child's school, you hereby forever release and discharge the District from any and all claims, actions and demands arising out of or in connection with the use of said video, motion picture, audio recording, web page, or still photograph, including, without limitation, any and all claims for invasion of privacy and libel. This release shall inure to the benefits of the assigns, licenses and legal representatives of the District, as well as the party for whom the District took the video, motion picture, audio recording, web page or still photograph.

If you wish to **deny** the District the use of your child's name, likeness, or voice in the manner described above and the right to use and reuse, in any manner at all, the video, motion picture, audio recording, web page, or still photograph productions, broadcasts, and/or publications as described above, **please complete the section below and return to your local school. If you fail to sign and return this form, it will be assumed that you have authorized consent for your child's name, likeness or voice to be used by the District in the manner described above.**

\_\_\_\_\_

Date

\_\_\_\_\_

School

\_\_\_\_\_

Student Full Name (Print)

\_\_\_\_\_

Grade

\_\_\_\_\_

Student I.D. #

I deny the District the use of my child's name, likeness, or voice in the manner described above and the right to use and reuse, in any manner at all, the video, motion picture, audio recording, web page, or still photograph productions, broadcasts, and/or publications as described above

\_\_\_\_\_

Parent/Guardian Full Name (Print)

\_\_\_\_\_

Parent/Guardian Signature

**Note to Principal or Office Manager:** Make a copy of this opt-out form and send the copy via District mail to the **PUSD Office of Communications**



PASADENA UNIFIED SCHOOL DISTRICT  
PARENTAL PERMISSION AND RELEASE FORM  
SCHOOL FIELD TRIPS AND/OR EXCURSIONS

**PLEASE NOTE:**

California State Education Code, Section 35330 in part provides:

All persons making the field trip or excursion shall be deemed to have waived all claims against the district, a charter school, or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion. All adults taking out-of-state field trips or excursions and all parents or guardians of pupils taking out-of-state field trips or excursions shall sign a statement waiving all claims. It is acknowledged that participation in the field trip is completely voluntary. There is no consequence if you choose not to have your child participate.

**PARENTAL PERMISSION**

Permission to participate in a school field or excursion any time during the school year is given as follows, by the parent/guardian:

My child, \_\_\_\_\_ whose school of attendance is \_\_\_\_\_ has my permission to participate in a school field trip or excursion any time during the school year.

This parental permission is for the period of \_\_\_\_\_ through \_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**\_\_\_ Please check here if instructions for special medical treatment for the student are on file in the school.**

**MEDICAL AUTHORIZATION**

Should it be necessary for my child to have medical treatment while participating in this trip, I hereby give the Pasadena Unified School District personnel permission to use their judgment in obtaining medical service for the child and I give permission to the physician selected by the Pasadena Unified School District personnel to render medical treatment deemed necessary and appropriate by the physician. I understand that the Pasadena Unified School District has no insurance covering such medical or hospital costs incurred for my child and, therefore, any cost incurred for such treatment shall be my sole responsibility.

School \_\_\_\_\_

Date \_\_\_\_\_

Student Name \_\_\_\_\_

Emergency Telephone No. \_\_\_\_\_

Address \_\_\_\_\_

Print Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_





PASADENA UNIFIED SCHOOL DISTRICT  
Early Childhood Education Programs

**Neighborhood Walking Trip Permit**

Occasionally during the year the preschool and school age programs will take short study trips near the school to add interest and meaning to their learning experiences. Advance preparations for good conduct and safety will be made with the children.

Your permission in writing is required before your son/daughter may leave the school grounds with the class on these trips, so you are requested to sign the permission slip below so it may be submitted to the preschool or school age teacher.

I, \_\_\_\_\_ hereby give my permission for  
(Name of Parent/Guardian)

\_\_\_\_\_ to go with his/her class on the short study  
(Name of Student)

**trips planned and conducted by the teacher. I understand that these are walking trips near**

**the school and adequate health and safety precautions will be taken.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date





**PASADENA UNIFIED SCHOOL DISTRICT**  
Early Childhood Education Programs

**Child's Individualized Time Sheet and  
Late Pick-Up Policy Acknowledgement Contract**

**Child's Individual Time Sheet**

Authorized individuals who are listed on the student's emergency card and are 18 years of age will need to arrive at the assigned and approved contracted hours. The actual time must be signed and written on the child's individual time sheet. If the proper time is not recorded, staff will be able to correct it for you and document it.

**Late Fees**

Families who arrive late to pick up their children beyond their contracted hours will be given a Late Pick-Up Notice. After three (3) late notifications have been given to a family, services may be transferred to better fit the needs of the family or removed if families do not comply with state regulations.

Families arriving after hours of operation will be given a notice and charged a late fee of \$1.00 for each minute that they are late. Late fees are to be paid within two weeks of the date the Late Pick-Up Notice was handed to the family or services will end immediately. All late fees are to be paid by money order and made payable to Pasadena Unified School District (PUSD).

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*I have read and understand that I must sign and record the proper time on my child's individual time sheet and that I must follow my assigned contract hours. I also understand that if my child is picked up late I will need to pay a late fee. Furthermore, I understand that my child may be disenrolled from the program after the third Late Pick-Up Notice.*

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Parent/Guardian Signature

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Date





PASADENA UNIFIED SCHOOL DISTRICT  
Early Childhood Education Programs



The Pasadena Unified School District’s Early Childhood Education Department would like to announce its participation with Peachjar eflyer. Peachjar eflyer manages flyer distribution on behalf of our preschool and School Age using the latest electronic communication technology.

Once our organization’s flyer is posted to our Peachjar site, the flyer is delivered to all parents’ email addresses as an embedded image, not a link. This means parents can immediately see the flyer and be able to click through to our organization’s website.

Flyers regarding preschool and School Age programs will be distributed to share with families any news, updates, meetings and upcoming events to help promote family participation within our programs. If a parent deletes the email and later wants some information from that flyer, the parent can view that flyer online by going to the school’s Peachjar website.

If you are interested in obtaining information regarding any events taking place within our Early Childhood Education office please provide the required information below.

Name of Enrolled Student: \_\_\_\_\_

Name of Enrolled School: \_\_\_\_\_

Name of Enrolling Parent: \_\_\_\_\_

Email Address Peachjar eflyer will be sent to: \_\_\_\_\_

Parent Signature of approval: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*Office Staff Use Only\*\*\*\*\*

Information entered into AERIES?  Yes  No Provide reason: \_\_\_\_\_

Person who entered data into AERIES: \_\_\_\_\_

