Appointment Time/Date

GUSD offers a free state preschool program, Monday- Friday 3 hours a day. Families must qualify based on their income (See Income Eligibility Guideline Chart below). Enrollment is **not on a first-come basis**. Priority for enrollment of eligible students is based on California Department of Education regulations (Must be a Gilroy resident):

- The first priority for services shall be given to three-year-old or four-year-old children who are recipients of child protective services or who are at risk of being neglected, abused, or exploited and for whom there is a written referral from a legal, medical, or social service agency.

You may find the complete list of priority for enrollment at:

https://www.cde.ca.gov/sp/cd/ci/mb2301.asp

Preschool Locations

Rod Kelley
(8755 Kern Avenue)

Antonio del Buono
(245 Farrell Avenue)

Glenview-NEW DI Program
(475 W 9th Street)

Registration for all sites takes place at Swanston by APPOINTMENT ONLY

Office Use

Child's Age _____ Fam Size _____ Rank _____

GUSD STATE PRESCHOOL PROGRAM
2024-2025

240 Swanston Lane, Gilroy CA 95020
(669) 205-7960

All documentation required at time of appointment.
Incomplete applications will not be accepted.

- ☐ **Proof of income for all individuals counted in the family size:** Pay stubs representing the **past 30 days from your appointment date**. Ensure that the pay stubs are **recent and that the dates are consecutive**. Missing stubs will **NOT** be accepted.
  - ◊ Weekly Pay – 4 pay stubs
  - ◊ Bi-Weekly Pay – 2 stubs
  - ◊ Twice a month – 2 pay stubs
  - ◊ Monthly pay – 1 stub
- ☐ Proof of any other income (unemployment, child support, TANF, cash aid, disability, social security, etc.) for the **past 30 days**
- ☐ Families with **varying income** (migrant, agricultural, or seasonal work) must submit income verification for the past **12 consecutive months**. Missing paystubs will **NOT** be accepted. Payroll summary for the past 12 months are acceptable.
- ☐ **Self-employed**, provide a combination of documentation necessary to establish current income eligibility from either month of the two-month window immediately preceding the initial certification. Documentation shall consist of as many of the following types of documentation as necessary to determine income: An independently drafted letter from the source of the income; A copy of the most recently signed and completed tax returns with a statement of current estimated income for tax purposes; or other business records, such as ledgers, receipts, or business logs.
- ☐ Physical Exam (done August 2023 or after) **May be pending for registration but must be turned in before August 5**
- ☐ Immunization Record- **Children will not be admitted without required immunizations or TB assessment**
  - Polio – 3 doses
  - DTP – 4 doses
  - Hep B – 3 doses
  - MMR – 1 dose on or after 1st birthday
  - Hib –One dose must be given on or after the 1st birthday regardless of previous doses.
- ☐ Completed TB Risk Assessment or TB Test if necessary
- ☐ Copy of birth certificates of **all your children in the household under the age of 18 years old** to establish family size.
- ☐ Proof of address: rental receipts or agreements, contracts, utility bills
- ☐ Attached forms filled out

If applicable

- ☐ Individualized Education Program (IEP)
- ☐ Records of Foster Care placements, legal guardianship

To schedule an appointment or for more information:
Lupe Vela
(669) 205-7960
email: lupe.vela@gilroyunified.org

If you do not qualify for our program, you may contact **Santa Clara County Childcare Resource & Referral Program:** Phone: 669-212-KIDS (5437), website https://www.childcarescc.org/child-care-application, Email: childcarescc@sccoe.org. The Childcare Resource & Referral (R&R) Program provides every family with the information they need to access high-quality early care and education that meets their specific preferences.

State Preschool Income Eligibility Guidelines effective 7/1/23

Family Size	1-2	3	4	5	6	7	8
Maximum Gross Monthly Income	$7,209	$8,154	$9,441	$10,952	$12,462	$12,745	$13,029

GUSD Preschool Program

GUSD Preschool Program

Office Use:

GILROY UNIFIED SCHOOL DISTRICT
2024-2025 PRESCHOOL STUDENT REGISTRATION

Student ID _____

Student Legal Name: Last First Middle	Birthdate: Birthplace, State or County	Male ☐ Female ☐ Other ☐
Mailing Address City Zip Code	MEDICAL PROBLEM: YES ☐ NO ☐	
Residence Address City Zip Code	LIST PROBLEMS: (Attach any additional information)	
Primary Phone:		
Emergency Contact- if responsible adult (parent, guardian) is unavailable: Name Address Phone		Month/year moved to current address

Has this student attended Gilroy Unified Schools in the past
Yes ☐ No ☐

School: _____

Grade: _____ Year: _____

List any sibling living in the home attending Gilroy Schools
Name School/Grade

_____

_____

_____

Has this student ever received any of the following services in this or any other District?

Gate Yes ☐ No ☐
504 Yes ☐ No ☐
Special Education* Yes ☐ No ☐
*(if yes, identify services)
Resource, Speech, Special Day

Previous School(s) (list Pre-school if applicable)

Grades Attended	Date Enrolled	Date Left	School	Public Yes	Public No	State	City	County

Home Language Survey

If you answer any language other than English for any of the questions below, your child will be required to take an ESL ELD Test

1. What language(s) does your child hear at home? *This includes, languages spoken by parents, grandparents, siblings, extended family or others living within or visiting the home.* _____

2. Which language(s) does your child hear in their neighborhood and community? *For example, with friends and neighbors, at church, or at after school programs or activities. This is to demonstrate language exposure not to measure language proficiency.* _____

3. Which language(s) does your child understand? _____

4. Which language(s) does your child speak? _____

Check all that Apply
☐Mother
☐Father
☐Foster Parent
☐Legal Guardian
☐Other (Specify)_____
Divorced/Legally Separated
☐ Yes ☐ No
If Yes, Joint Custody?
☐ Yes ☐ No
☐Emergency Contact?

Guardian Name: _____

_____

Address if different from student

Cell Phone: _____

Business Phone: _____

Email: _____

Education Level, College Year or Degree Obtain:
☐Not high school graduate ☐College Graduate
☐High School Graduate ☐Graduate School
☐Some College

Check all that Apply
☐Mother
☐Father
☐Foster Parent
☐Legal Guardian
☐Other (Specify)_____
Divorced/Legally Separated
☐ Yes ☐ No
If Yes, Joint Custody?
☐ Yes ☐ No
☐Emergency Contact?

Guardian Name: _____

_____

Address if different from student

Cell Phone: _____

Business Phone: _____

Email: _____

Education Level, College Year or Degree Obtain:
☐Not high school graduate ☐College Graduate
☐High School Graduate ☐Graduate School
☐Some College

SITE REQUESTED

This is a 3 hour program. Sessions times vary by site ☐ AM ☐ PM
Preferred preschool site/teacher: _____
☐ Rod Kelley ☐ Glen View ☐ Antonio Del Buono
☐ Glen View Dual Immersion (PM ONLY)

I UNDERSTAND THAT MY REQUEST IS TAKEN INTO CONSIDERATION BUT IT IS NOT GUARANTEED_____ initials

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND THAT MY SUPPORTING DOCUMENTS ARE CORRECT.

Parent/Guardian Signature_____ Date _____

Attachment B
Family Language and Interest Interview

Student's Name _____

Purpose and Framing

The purpose of this interview is to support relationship building with families with children who are identified as dual language learners and learn more about each child's experiences with language.

Identification of your child as a dual language learner in CSPP means that your child will benefit from additional support from the program in order to develop their home language and English language skills. This identification will serve them only in preschool and is different from any identification process or program supports a child might later receive as an English learner in TK or Kindergarten.

Family Language and Interest Interview Questions

1) What are your child's interests and favorite activities? (For example, does your child have favorite stories, books, and songs)

2) What are some strengths you see in your child that we can build on? (For example, do they like to build things, do art, etc.)

3) How can we help support your child's language and development at home? (For example, books to read at home, materials, activity ideas)

4) Young children love to talk, read, sing and are able to learn all the languages around them. Which language(s) does your child speak the most at home?

5) We want to best support your child's language development and understand what language(s) they speak with family members. What language(s) does your child speak with their siblings, grandparents, other family members?

6) Which language(s) does your child speak the most overall? This would be inside and outside of the home combined.

7) In what language would you prefer to receive written communication from us? (While we would like to be able to accommodate all requests for written communication in a parent's requested language, our program may not be able to translate written communication materials into that language.)

8) In what language would you prefer us to communicate verbally with you? (While we would like to be able to accommodate all requests for verbal communication in a parent's requested language, our program may not be able to offer translation into that language.)

Families' questions and concerns:

Resources to share regarding benefits of multilingualism and home language development:

- Ways to develop your child's bilingualism (Spanish): https://www.multilinguallearningtoolkit.org/wp-content/uploads/2021/08/Support-Billingualism-Spanish-1.pdf
- Keeping Your Home Language (available in 16 languages): https://cmascanada.ca/2018/05/15/keeping-your-home-language/
- Benefits of Multilingualism: https://ncela.ed.gov/files/announcements/20200805-NCELAInfographic-508.pdf

GUSD Preschool Program

Family Needs Assessment

Preschool would like to help meet the needs of the children and families we serve. Please help us by completing the following survey.

Child's Name_____ Parent's Name _____

Does your child go by any other name than their legal first name? If so, what's the name: _____

What language is spoken at home? ☐ English ☐ Spanish ☐ Other:_____

Do you have any concerns about your child in any of the following areas? If yes, please explain below.

YES	NO		YES	NO	
		Hearing			Learning/Cognitive Development
		Vision			Social Development
		Speech and Language			Physical Development
		Behavior/Emotional Development			Other

Concerns: _____

_____

If your child has a diagnosed special need, is it documented? ☐ IEP ☐ FSP ☐ 504 Plan Other_____

Would you like information or referrals for any of the following?

YES	NO		YES	NO	
		Food Assistance			Legal Services
		Housing			Family Counseling
		Nutrition			Parenting Education or Information
		Health/Immunizations			Dental Care
		Other:			Other:

Are there any specific topics you would like to see discussed at a parent meeting? If so, what?

_____

Parent Signature_____Date_____

FOR OFFICE USE ONLY			
		Date	
	Spoke to Parent		re:
	Gave Parent info		re:
	ASQ-SE given		returned on:
	Made referral on		to:
	Follow-up:		

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:

NAME

Community Care Licensing

ADDRESS

2580 N First Street Suite 300

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Jose	95131	(408) 324-2148

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)
GUSD Preschool Program	Gilroy CA 95020

(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

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: Community Care Licensing

   Licensing Office Address: 2580 N First Street Suite 300

   Licensing Office Telephone #: San Jose CA 95031 (408) 324-2148

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.

GUSD Preschool Program
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

Santa Clara County Pilot
Authorization to Contact Employer (07/01/18)

This form is ONLY to be used for services being provided by Part-Day CSPP programs.

Authorization to Contact Employer

Title 5 §18084 ((1)(A)) requires that parents/guardians who are employed must provide a release authorizing the contractor to contact the employer(s), to the extent known, that includes the following information:

I, _____ authorize
(parent/guardian printed name)

Gilroy Unified School District – Preschool Program ,
(name of agency)

to contract my employer, if needed, to verify income for the purpose of approval for preschool services.

Employer's Name: _____

Employer's Address: _____

Employer's Telephone #: _____

Usual Business Hours: _____

Parent/Guardian Signature: _____

Date: _____

☐ initials I feel that my employment will be at risk should my employer be contacted

Santa Clara County Pilot
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Gilroy Unified School District – Preschool Program,
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to contract my employer, if needed, to verify income for the purpose of approval for preschool services.

Employer's Name: _____

Employer's Address: _____

Employer's Telephone #: _____

Usual Business Hours: _____

Parent/Guardian Signature: _____

Date: _____

initials I feel that my employment will be at risk should my employer be contacted

GILROY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCE

7810 Arroyo Circle, Gilroy, California 95020
Tel. 669-205-4000
www.gilroyunified.org

2024-2025
Mobility Form
(CONFIDENTIAL)

Student's Name: _____ Date of Birth:_____

What is your Child's Ethnicity? (***Please Check One***)

- ☐ Hispanic or Latino (A person of Cuba, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
- ☐ Not Hispanic or Latino

What is your child's race? (Please check up to five racial categories)

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

☐American Indian or Alaskan Native (100) (persons having origins in any of the original people of North, Central or South America)
☐Chinese (201)
☐Japanese (202)
☐Korean (203)
☐Vietnamese (204)
☐Asian Indian (205)
☐Laotian (206)
☐Cambodian (207)
☐Hmong (208)
☐Other Asian (299)
☐Hawaiian (301)
☐Guamanian (302)
☐Samoan (303)
☐Tahitian (304)
☐Other Pacific Islander (399)
☐Filipino/Filipino American (400)
☐African American or Black (600)
☐White (700) (persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

MOBILITY *(Required/Mandated)*
1. Circle the grade in which you are enrolling your child. P K 1 2 3 4 5 6 7 8 9 10 11 12
2. Circle the grade when your child first entered/attended this district P K 1 2 3 4 5 6 7 8 9 10 11 12
3. When did/will your child first attend school in the United States? Month _____Yr _____

FIRST 5
SANTA CLARA COUNTY

ACKNOWLEDGMENT AND CONSENT

I, _____, as the parent, guardian or legally authorized
Parent name(s)

representative of _____
Child(ren)'s name(s)

have been informed and understand that FIRST 5 Santa Clara County may share confidential information about my family with other persons or agencies that work with FIRST 5 to plan and provide services to my family.

Participating agencies working with FIRST 5 to plan and provide services may include, but are not limited to: medical providers, the Behavioral Health Services Department, the Public Health Department, the Social Services Agency, Pre-school and Head Start Programs, the Regional Center, early education providers and other providers of early childhood services.

Each agency will only release or exchange confidential information or records to other participating agencies when the information may be relevant to the services to be provided or for evaluation purposes as explained below.

A separate authorization form is required for the release of medical information from a health care provider. I understand that I may be requested to sign other forms for the release of medical information.

I understand that FIRST 5 is required to conduct evaluations of the services they provide to my family. This requires collecting and analyzing information and data that may include confidential information about my family. I understand that this information will help improve services to families like mine and that no confidential information will be included in any public report.

FIRST 5 requires my permission to collect and analyze confidential information for evaluation purposes. Such information may be shared with FIRST 5 evaluators, partners and providers of early childhood services. Each agency understands that they must maintain the confidentiality of such information and can further disclose such information only as required by law or as authorized by a written consent to release the information. There are minimal risks to my family from sharing this information.

I give my permission to FIRST 5 and its evaluators and partners to collect and analyze my family's personal information for program evaluation purposes.

I understand that if I choose not to sign this Acknowledgment and Consent, my family will still receive services and for that purpose my name and address will be entered into the FIRST 5 database and will be available to the administrator of the database.

I also understand that I may cancel this consent at any time by writing to the Research and Evaluation Department, FIRST 5 Santa Clara County, 4000 Moorpark Avenue, Suite 200, San Jose, CA 95117. Cancellation of my permission will not affect any information that has already been collected.

This consent shall remain in effect for 10 years.

FIRST 5
SANTA CLARA COUNTY

ACKNOWLEDGMENT AND CONSENT
(continued)

I have read this form, or it has been fully explained to me, and I understand the provisions.

Parent(s), Legal Guardian or Legal Representative:

Print Name	Print Name
Signature	Signature
Relationship to Child(ren)	Relationship to Child(ren)

Child(ren)'s Name(s)

Date

GUSD Preschool Program
Name of Agency obtaining parent signature and holding original form

Lupe Vela
Name of Person obtaining parent signature

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

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

GUSD Preschool Program
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'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

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)

GUSD Preschool . This Child Care Center/School provides a program which extends from 3 : hrs
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m., 5 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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

Child's Name:_____ Birthdate: _____ Male/Female School: GUSD- Preschool
Last, First month/day/year

Address_____ Phone:_____ Grade: Preschool
Street City Zip

Santa Clara County Public Health Department
Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a licensed health professional in the U.S. and returned to the child's school.

1. Was your child born in, resided, or traveled (for more than one month) to a country with an elevated rate of TB*? ❑ Yes ❑ No
2. Has your child been in close contact to anyone with TB disease in their lifetime? ❑ Yes ❑ No
3. Is your child immunosuppressed; current, or planned? (e.g., due to HIV infection, organ transplant, treatment with TNF-alpha antagonist or high-dose systemic steroids (e.g., prednisone ≥ 15 mg/day for ≥ 2 weeks). ❑ Yes ❑ No

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e., travel that does not involve visiting family or friends, or involve significant contact with the local population).

If YES, to any of the above questions, the child has an increased risk of TB and should have a TB blood test or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in US or TST performed at age ≥ 6 months in U.S.)

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Date of (IGRA)	Result: ❑ Negative ❑ Positive ❑ Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD) Date placed: Date read:	Induration_____mm Result: ❑ Negative ❑ Positive
Chest X-Ray Date: _ Impression: ❑ Normal ❑ Abnormal	
LTBI Treatment Start Date: _____ ☐ Rifampin daily - 4 months ☐ Isoniazid/Rifapentine - weekly X 12 weeks ☐ Isoniazid daily - 9 months ☐ Isoniazid and Rifampin daily - 3 advice months	☐ Prior TB/LTBI treatment (Rx & duration): _____ ☐ Treatment medically contraindicated ☐ Declined against medical

Please check one of the boxes below and sign:

☐ Child has no TB symptoms, no risk factors for TB, and does not require a TB test.
☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.
☐ Child has no new risk factors since last negative IGRA/TST and has no symptoms.
☐ Child has no TB symptoms. Appointment for IGRA/TST scheduled on: _____ _____.
☐

_____
Health Care Provider Signature, Title Date

Name/Title of Health Provider:
Facility/Address:
Phone number: