



FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT SELPA

Special Education Department

1965 Birkmont Drive ▪ Rancho Cordova, CA 95742

(916) 294-9007 ▪ FAX (916) 294-9023

Dear Parent/Guardian,

Thank you for your interest in FCUSD's Early Childhood Assessment for preschool. Attached are the forms necessary to register your preschool-aged child and determine if he/she would benefit from formal assessment(s). Please complete the attached forms and return them to me with copies of proof of residency, your child's birth certificate and immunization record by email (SPED-ECAT@fcusd.org), fax or US mail to:

FCUSD Student Support Services
1965 Birkmont Drive
Rancho Cordova, CA 95742
Attention: Amy Flynn / ECAT

- **Contact and Residency Information Form and proof of residency such as:**

Utility bills, Driver's License, pay stubs, voter registration documents, rental contract, mortgage statement, or other government documents that show the address of residence.

- **Confidential Health History Form**

Please complete the form to the best of your ability even though some questions may be difficult to answer. Circle the words on the vocabulary worksheet to indicate which words your child currently says or attempts to say on his/her own. These words do not need to be pronounced correctly. (For example, if your child says "wa-wa" for "water," the word "water" should be circled.)

- **Child's Birth Certificate (copy)**

If you do not have a birth certificate for your child, you can obtain a copy by contacting the Clerk-Recorder for the county in which the child was born. Other acceptable forms of proof of age are your child's passport, hospital announcement or baptism record.

- **Child's Immunization Record (copy)**

- **Copies of any previous assessments/reports, if applicable**

Thank you,

Amy Flynn
ECAT Admin. Assistant
916-294-9007 ext 102425
916-294-9023 (fax)
SPED-ECAT@fcusd.org

Encl: Procedural Safeguards
Contact/Residency Form
Health History Form

FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT
PRESCHOOL CONTACT AND RESIDENCY INFORMATION

STUDENT INFORMATION:

Legal Name as it appears on your child's birth certificate:

(First, Middle, Last)
Other Name: (if used): _____ Sex: ☐ M ☐ F Birthdate: ____/____/____
Home Address: _____ City: _____ Zip: _____
Mailing Address: (if different): _____
Email Address: _____
Student Lives with: _____
If parents are divorced/separated, to whom has physical custody been granted?
_____ Custody papers on file? ☐ Yes ☐ No

Student's Ethnicity (check all that apply):

- | | | | |
|--|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Native American | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Tahitian |
| <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| | | <input type="checkbox"/> Filipino | <input type="checkbox"/> White |

Student's Primary Language _____ Home Language _____

Please list all schools / school districts your student has attended:

SCHOOL NAME: _____ DISTRICT NAME: _____

Highest education received between all of the student's parents/guardians:

Please check one:

Parent/Guardian 1 Name: _____	Parent/Guardian 2 Name: _____
<input type="checkbox"/> Graduate Degree or Higher	<input type="checkbox"/> Graduate Degree or Higher
<input type="checkbox"/> College Graduate	<input type="checkbox"/> College Graduate
<input type="checkbox"/> Some College or Associates Degree	<input type="checkbox"/> Some College or Associates Degree
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> High School Graduate
<input type="checkbox"/> Not a High School Graduate	<input type="checkbox"/> Not a High School Graduate
<input type="checkbox"/> Decline to State	<input type="checkbox"/> Decline to State

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child in order of reference to:

Name: _____ Home Phone: _____

Cell Phone: _____

Check one: ☐ Neighbor ☐ Relative ☐ Daycare ☐ Other: _____

Name: _____ Home Phone: _____

Cell Phone: _____

Check one: ☐ Neighbor ☐ Relative ☐ Daycare ☐ Other: _____

Affidavit of Residency

In accordance with Folsom Cordova Unified School District Policy 5117, I hereby declare that I reside with my student at the address indicated on this form. Falsifying this address will result in immediate disenrollment.

I confirm that all information on this form is true under penalty of perjury.

Signature of parent/legal guardian

Printed name of parent/legal guardian

Date



FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT SELPA
SPECIAL EDUCATION DEPARTMENT
1965 Birkmont Drive, Suite 206, Rancho Cordova, CA 95742
(916) 294 9007
FAX (916) 294-9023

Health History Form
Confidential

Person filling out form: _____

DATE: _____ Child's Full Name: _____

Child's nickname: _____ Ethnicity: _____ Birthdate: _____

Parent/Guardian 1: _____ Employer: _____

Relationship to child: _____

Phone Numbers: home: _____ cell: _____ work: _____

Parent/Guardian 2: _____ Employer: _____

Relationship to child: _____

Phone Numbers: home: _____ cell: _____ work: _____

Who does your child live with?: _____

Address where your child lives: _____

Siblings: _____ age: _____

_____ age: _____

_____ age: _____

_____ age: _____

Who referred your child for an evaluation? _____

What is the reason(s) your child was referred? _____

Name and address of preschool your child attends: _____

Days and time of attendance: _____

First and last name of preschool teacher: _____

Name of elementary school your child will attend as a Kindergartener: _____

When will your child begin Kindergarten? _____

PRENATAL HISTORY:

Prenatal care began at _____ months. Explain any problems during pregnancy:

Significant Family Health History:

☐ Alcohol

☐ Diabetes

☐ High Blood Pressure

☐ Smoking

☐ Toxemia

BIRTH HISTORY

Was your child premature? _____ If yes, how early? _____

Type of delivery: ☐ vaginal ☐ c-section

Weight of baby: _____ APGAR score (if known): _____

Were you told of problems during birth or after? ☐ Yes ☐ No

Was your child blue at birth? ☐ Yes ☐ No

Was oxygen required? ☐ Yes ☐ No

Was anesthesia required? ☐ Yes ☐ No

Was the cord wrapped around the neck? ☐ Yes ☐ No

Was your child kept in the hospital for medical reasons after birth? ☐ Yes ☐ No

If yes, for how long? _____ For what reason? _____

Did your child experience feeding or sucking problems while in the hospital?

If so, what were the issues? ☐ Yes ☐ No

FEEDING HISTORY

Did your child have problems with breastfeeding or bottle-feeding? ☐ Yes ☐ No

If so, please explain:

Did you stop breastfeeding early because you thought you didn't have enough milk? ☐ Yes ☐ No

Does your child experience nasal regurgitation when feeding? ☐ Yes ☐ No

Does your child need special equipment for feeding? _____ ☐ G-tube ☐ NG-tube

Does your child currently use a bottle? ☐ Yes ☐ No Age stopped: _____

Does your child currently use a pacifier? ☐ Yes ☐ No Age stopped: _____

Does your child currently use a sippy cup? ☐ Yes ☐ No Age stopped: _____

Does your child currently suck on his/her thumb? ☐ Yes ☐ No Age stopped: _____

When did your child start on solid food? _____

What was the transition to solid foods like? _____

What are your child's favorite foods? _____

What does your child refuse to eat? _____

Does your child spit out any food after chewing? ☐ Yes ☐ No

If so, please list the type of food:

Does your child "stuff" a lot of food into his/her mouth? ☐ Yes ☐ No

Does your child favor spicy foods? ☐ Yes ☐ No

Does your child drool? ☐ Yes ☐ No

Does your child know how to chew gum? ☐ Yes ☐ No

HEARING AND VISION

Has your child had ear infections? ☐ Yes ☐ No How many? _____
If so, at what age did the ear infections start? _____ If they stopped, when did they stop? _____
Were the ear infections chronic? (occurring almost non-stop) ☐ Yes ☐ No
Were pressure equalizing tubes inserted? ☐ Yes ☐ No
If so, when were they inserted and by which doctor?

Are the tubes still in place in both ears? ☐ Yes ☐ No
Has your child had a hearing test? ☐ Yes ☐ No
If so, where was the test done?
_____ When was the last hearing test? _____
What the result of the hearing test? Left ear _____ Right ear _____

Has your child had a vision test? ☐ Yes ☐ No When was the vision test? _____
What were the results of the vision test? Left eye _____ Right eye _____
Does your child wear glasses? ☐ Yes ☐ No

HEALTH HISTORY

Has your child had any high temperatures? ☐ Yes ☐ No
If so, when? _____
Has your child had any seizures? ☐ Yes ☐ No
If so, when? _____
Has your child had any surgeries? ☐ Yes ☐ No
If so, what surgeries were done?
(list type of surgery and date):

Does your child often clear their voice? ☐ Yes ☐ No
Does your child often sound hoarse? ☐ Yes ☐ No
Does your child have a chronic cough? ☐ Yes ☐ No
Does your child often speak in a loud voice? ☐ Yes ☐ No
Does your child often sound like they
have a cough when they don't? ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No
Is your child a mouth breather? ☐ Yes ☐ No
Does your child have allergies? ☐ Yes ☐ No

If so, what kind? _____
Does your child take any drugs or
medications routinely? ☐ Yes ☐ No
If so, please list: _____

Has your child had any serious accidents, injuries, or been in an automobile accident?

☐ Yes ☐ No If so, please describe: _____

Has your child had pneumonia? ☐ Yes ☐ No

When was your last pediatrician visit? _____

What is your pediatrician's name? _____ Phone number? _____

Are your child's immunizations up to date? ☐ Yes ☐ No

Is your child toilet trained? ☐ Yes ☐ No At what age were they trained? _____

SIGNIFICANT FAMILY HEALTH HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Special Education | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diabetes | Services | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcoholism | |

Comment/Other: _____

SPEECH AND LANGUAGE HISTORY

Was your child unusually quiet as a baby? ☐ Yes ☐ No
(for instance, didn't coo or babble much)

Does your child look at you when communicating? ☐ Yes ☐ No

Has your child ever used more language than they currently do? ☐ Yes ☐ No

Is English your child's primary language? ☐ Yes ☐ No

If no, what is your child's primary language? _____

What percentage of the time do you speak to your child in English? _____

When did your child say their first word? _____

When did your child begin to combine words? _____

When did your child speak in complete sentences? _____

List three simple gestures your child uses (for example: "bye bye" or raises arms up for "up")

I am concerned that my child is having difficulty: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Producing sounds and words | <input type="checkbox"/> Producing understandable sentences |
| <input type="checkbox"/> Learning names for things | <input type="checkbox"/> Understanding verbal direction |
| <input type="checkbox"/> Recalling the names for things | <input type="checkbox"/> Answering questions |
| <input type="checkbox"/> Having conversations | <input type="checkbox"/> Speaking smoothly |
| <input type="checkbox"/> Using correct grammar | <input type="checkbox"/> Interacting socially with peers |
| <input type="checkbox"/> Paying attention when people talk | <input type="checkbox"/> Paying attention when read to |
| <input type="checkbox"/> Playing with peers | <input type="checkbox"/> Taking turns |

Please describe these concerns further and/or add concerns not listed above:

GROSS MOTOR DEVELOPMENT

Age when your child first:

Sat without support _____

Crawled _____

Walked _____

Does your child:

Ride a bike? ☐ Yes ☐ No

Hop on two feet? ☐ Yes ☐ No

Hop on one foot? ☐ Yes ☐ No

Is your child as coordinated as others their age? ☐ Yes ☐ No

FINE MOTOR SKILLS

Does your child use a:

Fork? ☐ Yes ☐ No

Spoon? ☐ Yes ☐ No

Pencil? ☐ Yes ☐ No

Scissors? ☐ Yes ☐ No

What hand does your child seem to prefer? _____

Does your child have difficulty manipulating small objects? ☐ Yes ☐ No

PLAY SKILLS

Check all of the activities your child likes to do:

- | | | |
|---|---|---|
| <input type="checkbox"/> Dress up | <input type="checkbox"/> Building with blocks | <input type="checkbox"/> Tea Parties |
| <input type="checkbox"/> Cutting | <input type="checkbox"/> Games | <input type="checkbox"/> Looking at books |
| <input type="checkbox"/> Being read to | <input type="checkbox"/> Puzzles | <input type="checkbox"/> Pasting |
| <input type="checkbox"/> Action figures | <input type="checkbox"/> Coloring | <input type="checkbox"/> Painting |
| <input type="checkbox"/> Cars and Trucks | <input type="checkbox"/> Sandbox | <input type="checkbox"/> Trains |
| <input type="checkbox"/> Going to the Park | <input type="checkbox"/> Water play | <input type="checkbox"/> Helping to cook |
| <input type="checkbox"/> Using stuffed animals as playmates | | |
| <input type="checkbox"/> Play catch and toss games | | |

Please list other activities your child enjoys: _____

Does your child like to play with other children? ☐ Yes ☐ No

Is your child's play different from others their age?
If so, how? ☐ Yes ☐ No

SOCIAL EMOTIONAL BEHAVIORAL

Do you have concerns about behavior? ☐ Yes ☐ No
If so, please explain:

Has your child been diagnosed with ADD or ADHD? ☐ Yes ☐ No

Has your child been diagnosed with PDD or Autism? ☐ Yes ☐ No

Describe your child's energy level:

Describe your child's emotional and social development (i.e., shy, friendly, aggressive, sensitive, etc.)

Does your child spend time with other children the same age?

☐ Yes ☐ No If so, please share how much time per week? _____

What social opportunities has your child had with other children? (please check all that apply):

☐ Daycare

☐ Preschool

☐ Parks

☐ Social gatherings

☐ Community events

☐ Community play groups

☐ Social interaction with:

☐ Siblings

☐ Neighbors

☐ Family

Other: _____

Describe your child's social opportunities with others:

Describe your child's strengths and weaknesses:

PREVIOUS EVALUATIONS/SERVICES

My child has had the following evaluations previously completed:

<input type="checkbox"/> Speech and Language	Where? _____	When? _____
<input type="checkbox"/> Occupational Therapy	Where? _____	When? _____
<input type="checkbox"/> Physical Therapy	Where? _____	When? _____
Other: _____	Where? _____	When? _____
<input type="checkbox"/> Other: _____	Where? _____	When? _____

My child has had the following Services:

<input type="checkbox"/> Speech and Language Therapy	Where? _____	When? _____
<input type="checkbox"/> Occupational Therapy	Where? _____	When? _____
<input type="checkbox"/> Physical Therapy	Where? _____	When? _____
<input type="checkbox"/> Applied Behavioral Analysis (ABA)	Where? _____	When? _____
<input type="checkbox"/> Child Development	Where? _____	When? _____
<input type="checkbox"/> Feeding Therapy	Where? _____	When? _____
<input type="checkbox"/> Other: _____	Where? _____	When? _____
<input type="checkbox"/> Other: _____	Where? _____	When? _____

Was your child enrolled in services in another school district? Yes No

If so, when and where?

Have any of your child's siblings received early education or special education services?

☐ Yes ☐ No If so, where? _____ when? _____

Is there a family history of speech/language/learning difficulties in your immediate or distant family?

☐ Yes ☐ No If so, please explain (e.g., cleft palate, hearing loss, learning difficulties, stuttering, speech delay)

PREACADEMIC

List any preacademic skills your child knows:

- Colors: _____
- Shapes: _____
- Letters: _____
- Numbers: _____
- Counting: _____

Does your child have screen time (i.e. tablet, phone, TV)?

☐ Yes ☐ No If so, how much time per day? _____

Describe your child's interaction with technology / devices:

MISCELLANEOUS:

Does your child understand danger?

☐ Yes ☐ No

Does your child have a sense of right and wrong?

☐ Yes ☐ No

Is your child sensitive or bothered by certain noises?

☐ Yes ☐ No

Does your child show extreme resistance to hair or teeth brushing?

☐ Yes ☐ No

What is your biggest concern about your child at this time?

Check the boxes that indicate which words your child currently says or attempts to say on their own.

These words do not need to be pronounced correctly (e.g., if your child says “wawa” for water then that word should be checked)

<u>FOOD</u>	<u>ANIMALS</u>	<u>ACTIONS</u>	<u>HOUSEHOLD</u>	<u>PERSONAL</u>	<u>CLOTHES</u>	<u>MODIFIERS</u>	<u>OTHER</u>
<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL	<input type="checkbox"/> ALL
<input type="checkbox"/> Apple	<input type="checkbox"/> Bear	<input type="checkbox"/> Bathe	<input type="checkbox"/> Bathtub	<input type="checkbox"/> Brush	<input type="checkbox"/> Belt	<input type="checkbox"/> All gone	<input type="checkbox"/> A, B, C
<input type="checkbox"/> Banana	<input type="checkbox"/> Bee	<input type="checkbox"/> Bring	<input type="checkbox"/> Bed	<input type="checkbox"/> Come	<input type="checkbox"/> Boots	<input type="checkbox"/> Alright	<input type="checkbox"/> Away
<input type="checkbox"/> Bread	<input type="checkbox"/> Bird	<input type="checkbox"/> Catch	<input type="checkbox"/> Blanket	<input type="checkbox"/> Glasses	<input type="checkbox"/> Boar	<input type="checkbox"/> Bad	<input type="checkbox"/> Boo-boo
<input type="checkbox"/> Burger	<input type="checkbox"/> Bug	<input type="checkbox"/> Clap	<input type="checkbox"/> Bottle	<input type="checkbox"/> Key	<input type="checkbox"/> Diaper	<input type="checkbox"/> Big	<input type="checkbox"/> Bye
<input type="checkbox"/> Cake	<input type="checkbox"/> Bunny	<input type="checkbox"/> Come	<input type="checkbox"/> Bowl	<input type="checkbox"/> Money	<input type="checkbox"/> Dress	<input type="checkbox"/> Black	<input type="checkbox"/> Cursing
<input type="checkbox"/> Candy	<input type="checkbox"/> Cat	<input type="checkbox"/> Cough	<input type="checkbox"/> Chair	<input type="checkbox"/> Paper	<input type="checkbox"/> Gloves	<input type="checkbox"/> Blue	<input type="checkbox"/> Here
<input type="checkbox"/> Cereal	<input type="checkbox"/> Chicken	<input type="checkbox"/> Dance	<input type="checkbox"/> Clock	<input type="checkbox"/> Pan	<input type="checkbox"/> Hat	<input type="checkbox"/> Broken	<input type="checkbox"/> Hi, hello
<input type="checkbox"/> Cheese	<input type="checkbox"/> Cow	<input type="checkbox"/> Eat	<input type="checkbox"/> Crib	<input type="checkbox"/> Pencil	<input type="checkbox"/> Jacket	<input type="checkbox"/> Clean	<input type="checkbox"/> In
<input type="checkbox"/> Coffee	<input type="checkbox"/> Dog	<input type="checkbox"/> Finish	<input type="checkbox"/> Cup	<input type="checkbox"/> Penny	<input type="checkbox"/> Mittens	<input type="checkbox"/> Cold	<input type="checkbox"/> Me
<input type="checkbox"/> Cookie	<input type="checkbox"/> Duck	<input type="checkbox"/> Fix	<input type="checkbox"/> Door	<input type="checkbox"/> Tissue	<input type="checkbox"/> Pajamas	<input type="checkbox"/> Dark	<input type="checkbox"/> Meow
<input type="checkbox"/> Crackers	<input type="checkbox"/> Elephant	<input type="checkbox"/> Get	<input type="checkbox"/> Floor	<input type="checkbox"/> Toothbrush	<input type="checkbox"/> Pants	<input type="checkbox"/> Dirty	<input type="checkbox"/> My
<input type="checkbox"/> Drink	<input type="checkbox"/> Fish	<input type="checkbox"/> Give	<input type="checkbox"/> Fork	<input type="checkbox"/> Umbrella	<input type="checkbox"/> Shirt	<input type="checkbox"/> Down	<input type="checkbox"/> Myself
<input type="checkbox"/> Egg	<input type="checkbox"/> Frog	<input type="checkbox"/> Go	<input type="checkbox"/> Glass	<input type="checkbox"/> Watch	<input type="checkbox"/> Shoes	<input type="checkbox"/> Good	<input type="checkbox"/> Night-night
<input type="checkbox"/> Food	<input type="checkbox"/> Horse	<input type="checkbox"/> Have	<input type="checkbox"/> Knife		<input type="checkbox"/> Slippers	<input type="checkbox"/> Happy	<input type="checkbox"/> No
<input type="checkbox"/> Grapes	<input type="checkbox"/> Monkey	<input type="checkbox"/> Help	<input type="checkbox"/> Light	<u>PEOPLE</u>	<input type="checkbox"/> Sneakers	<input type="checkbox"/> Heavy	<input type="checkbox"/> Off
<input type="checkbox"/> Gum	<input type="checkbox"/> Pig	<input type="checkbox"/> Hit	<input type="checkbox"/> Mirror	<input type="checkbox"/> ALL	<input type="checkbox"/> Socks	<input type="checkbox"/> Hot	<input type="checkbox"/> On
<input type="checkbox"/> Hot dog	<input type="checkbox"/> Puppy	<input type="checkbox"/> Hug	<input type="checkbox"/> Pillow	<input type="checkbox"/> Aunt	<input type="checkbox"/> Sweater	<input type="checkbox"/> Little	<input type="checkbox"/> Out
<input type="checkbox"/> Ice	<input type="checkbox"/> Snake	<input type="checkbox"/> Jump	<input type="checkbox"/> Plate	<input type="checkbox"/> Baby		<input type="checkbox"/> Mine	<input type="checkbox"/> Please
cream	<input type="checkbox"/> Tiger	<input type="checkbox"/> Kick	<input type="checkbox"/> Potty	<input type="checkbox"/> Boy	<u>OUTDOOR</u>	<input type="checkbox"/> More	<input type="checkbox"/> Excuse me
<input type="checkbox"/> Juice	<input type="checkbox"/> Turkey	<input type="checkbox"/> Kiss	<input type="checkbox"/> Radio	<input type="checkbox"/> Daddy	<input type="checkbox"/> ALL	<input type="checkbox"/> Open	<input type="checkbox"/> Thank you
<input type="checkbox"/> Meat	<input type="checkbox"/> Turtle	<input type="checkbox"/> Knock	<input type="checkbox"/> Room	<input type="checkbox"/> Doctor	<input type="checkbox"/> Flower	<input type="checkbox"/> Pretty	<input type="checkbox"/> There
<input type="checkbox"/> Milk		<input type="checkbox"/> Look	<input type="checkbox"/> Sink	<input type="checkbox"/> Girl	<input type="checkbox"/> Mouse	<input type="checkbox"/> Red	<input type="checkbox"/> Under
<input type="checkbox"/> Orange	<u>BODY</u>	<input type="checkbox"/> Love	<input type="checkbox"/> Soap	<input type="checkbox"/> Grandma	<input type="checkbox"/> Moon	<input type="checkbox"/> Shut	<input type="checkbox"/> Welcome
<input type="checkbox"/> Pizza	<u>PARTS</u>	<input type="checkbox"/> Make	<input type="checkbox"/> Sofa	<input type="checkbox"/> Grandpa	<input type="checkbox"/> Rain	<input type="checkbox"/> Stinky	<input type="checkbox"/> What
<input type="checkbox"/> Pretzel	<input type="checkbox"/> ALL	<input type="checkbox"/> Nap	<input type="checkbox"/> Spoon	<input type="checkbox"/> Lady	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> That	<input type="checkbox"/> Where
<input type="checkbox"/> Soda	<input type="checkbox"/> Arm	<input type="checkbox"/> Peepee	<input type="checkbox"/> Stairs	<input type="checkbox"/> Man	<input type="checkbox"/> Snow	<input type="checkbox"/> This	<input type="checkbox"/> Why
<input type="checkbox"/> Spaghetti	<input type="checkbox"/> Belly	<input type="checkbox"/> Push	<input type="checkbox"/> Table	<input type="checkbox"/> Mommy	<input type="checkbox"/> Star	<input type="checkbox"/> Tired	<input type="checkbox"/> Woof-woof
<input type="checkbox"/> Tea	<input type="checkbox"/> Bottom	<input type="checkbox"/> Read	<input type="checkbox"/> Telephone	<input type="checkbox"/> Own	<input type="checkbox"/> Street	<input type="checkbox"/> Up	<input type="checkbox"/> Yes
<input type="checkbox"/> Toast	<input type="checkbox"/> Chin	<input type="checkbox"/> Ride	<input type="checkbox"/> Towel	name	<input type="checkbox"/> Sun	<input type="checkbox"/> Wet	<input type="checkbox"/> You
<input type="checkbox"/> Water	<input type="checkbox"/> Elbow	<input type="checkbox"/> Run	<input type="checkbox"/> Trash	<input type="checkbox"/> Pet name	<input type="checkbox"/> Tree	<input type="checkbox"/> White	<input type="checkbox"/> Yum
	<input type="checkbox"/> Eye	<input type="checkbox"/> See	<input type="checkbox"/> TV	<input type="checkbox"/> Uncle		<input type="checkbox"/> Yellow	<input type="checkbox"/> 1, 2, 3
<u>TOYS</u>	<input type="checkbox"/> Face	<input type="checkbox"/> Show	<input type="checkbox"/> Window			<input type="checkbox"/> Yuck	
<input type="checkbox"/> ALL	<input type="checkbox"/> Finger	<input type="checkbox"/> Sing		<u>VEHICLES</u>			
<input type="checkbox"/> Ball	<input type="checkbox"/> Hair	<input type="checkbox"/> Sit	<u>PLACES</u>	<input type="checkbox"/> ALL			
<input type="checkbox"/> Balloon	<input type="checkbox"/> Hand	<input type="checkbox"/> Sleep	<input type="checkbox"/> ALL	<input type="checkbox"/> Bike			
<input type="checkbox"/> Blocks	<input type="checkbox"/> Knee	<input type="checkbox"/> Stop	<input type="checkbox"/> Church	<input type="checkbox"/> Boat			
<input type="checkbox"/> Bubble	<input type="checkbox"/> Leg	<input type="checkbox"/> Take	<input type="checkbox"/> Home	<input type="checkbox"/> Bus			
<input type="checkbox"/> Crayon	<input type="checkbox"/> Mouth	<input type="checkbox"/> Throw	<input type="checkbox"/> Hospital	<input type="checkbox"/> Car			
<input type="checkbox"/> Doll	<input type="checkbox"/> Neck	<input type="checkbox"/> Tickle	<input type="checkbox"/> Library	<input type="checkbox"/> Motorbike			
<input type="checkbox"/> Present	<input type="checkbox"/> Nose	<input type="checkbox"/> Walk	<input type="checkbox"/> Park	<input type="checkbox"/> Plane			
<input type="checkbox"/> Slide	<input type="checkbox"/> Teeth	<input type="checkbox"/> Want	<input type="checkbox"/> School	<input type="checkbox"/> Stroller			
<input type="checkbox"/> Swing	<input type="checkbox"/> Thumb	<input type="checkbox"/> Wash	<input type="checkbox"/> Store	<input type="checkbox"/> Train			
<input type="checkbox"/> Teddy	<input type="checkbox"/> Toe		<input type="checkbox"/> Zoo	<input type="checkbox"/> Trolley			
Bear	<input type="checkbox"/> Tummy			<input type="checkbox"/> Truck			

Please list any other words your child uses: _____

Please list below three of your child's longest sentences or phases:

- 1) _____
- 2) _____
- 3) _____

Folsom Cordova Unified School District

1965 Birkmont Drive, Rancho Cordova, CA 95742
Angela Griffin Ankhelyi - Chief officer, Communications and Community Engagement
Phone Number: 916-294-9014 Fax: 916-294-9020



It is the policy of Folsom Cordova Unified School District to require written permission before using photos or video footage that identifies a student with an individualized education program.

2024-2025 PARENT CONSENT FORM

PHOTOS/VIDEOS IDENTIFYING STUDENTS WITH INDIVIDUALIZED EDUCATION PROGRAMS

Student Name: _____ Student ID #: _____

Date: _____ School: _____

The Folsom Cordova Unified School District and/or school representatives' requests permission to photograph or videotape the student indicated above during the 2024-2025 school year. The photos and videos may be used for school or District purposes including but not limited to classroom instruction and curriculum, newsletters, student awards, District print publications, television programming, and/or web sites including District social media platforms.

I, the parent and/or legal guardian of _____, do consent and grant my permission to use photos and videos identifying my student for:

(please check one or both options)

- ☐ School purposes such as classroom instruction and curriculum, newsletters and student awards
- ☐ District purposes such as print publications, television programming, and/or websites including District social media platforms

Parent/Guardian name (please print)

Signature of parent and/or guardian

Street Address

Date

City/State/Zip Code

Telephone (with area code)

This consent form will be kept on file at the school of the above-named student.

July 2024



Folsom Cordova Unified School District

Consent Form for the District's Participation in the LEA Medi-Cal Billing Program

Dear Parent/Guardian,

The Folsom Cordova Unified School District, in cooperation with the California Departments of Health Care Services and Education, participates in a program that allows the district to be reimbursed with federal Medicaid dollars for select health services provided to Medi-Cal eligible students at school. This program greatly benefits our district and our families—all reimbursements the school receives are required to be incorporated back into the health and social services programs for our students; they also help to offset the costs the district incurs providing these services.

In order for the district to receive reimbursement for these services, we must obtain your consent to release select education records to the Department of Health Care Services (DHCS) and, we must obtain your consent to access public benefits if your child is enrolled in Medi-Cal.¹

Regardless of your response, students will not be denied services they require to attend school and the district will never bill you for services provided because of your consent or non-consent. Further, while Medi-Cal is reimbursing the district for select health services, your Medi-Cal benefits should not be impacted. We participate in this program in an effort to obtain federal funding for the Medi-Cal reimbursable health services already being performed at school, and then use this funding to expand services for all students.

We discuss parental consent with all of our families so that if your child is, or may ever become eligible for Medi-Cal, your consent allows the district, in a confidential manner, to submit eligible services for reimbursement. This means that even if your student is not enrolled in Medi-Cal, your consent (or non-consent) is still needed. **Please complete the below form and return it to your school.**

Child's Name: _____ **Date of Birth:** _____

By signing below, I acknowledge the following:

- *I have a right to request that this form be provided in any native language, or through another mode of communication.*
- *The education records that may be shared include: child's name and date of birth; health-related evaluation, intervention, and referral information (for services received at school); practitioners' notes related to these health services; and, select data from child's IEP/IFSP (if applicable)*
- *I understand that consent is voluntary, and the consent may be revoked at any time.*
- *If my child is enrolled in Medi-Cal and is also covered by a third party insurer, DHCS may attempt to recover third party liability if they pay a school-based claim submitted by the district. This occurs due to the assignment of third-party liability rights that was provided when your application to Medi-Cal was approved.*
- *I have been notified that my refusal to allow access to public benefits does not relieve the district of its responsibility to ensure that all services required by FAPE are provided at no cost to me.*
- *Consent hereafter is satisfied by an annual notification provided by the district, acknowledging participation in the LEA Medi-Cal Billing Program and related parent rights.*

Please mark your choice:

☐ **I consent to the release of my child's related health records, and access to my child's Medi-Cal benefits**

☐ **I do not consent to the release of my child's related health records, or access to my child's Medi-Cal benefits**

Parent/Guardian Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

¹ The requirements for parental consent are outlined in the Individuals with Disabilities Education Act (IDEA) 34 CFR 300.154, and Family Educational Rights and Privacy Act (FERPA) 34 CFR Part 99.



FAQs – Medicaid Billing for School-Based Services

1. Will I ever be billed for school-based services that my child receives?

No. You will never receive a bill from the district, and there is no cost to you or to your child for school-based health services, regardless of your child's Medicaid eligibility. Bills for eligible school-based services provided to children who are Medicaid eligible are submitted to Medicaid for reimbursement.

2. Do I have to be involved in the billing process in any way?

You will only be asked to provide the district with your consent for Medicaid billing. Parents have no other responsibilities in this process.

3. Does this program (and my consent) impact my child's Medicaid benefits in any way?

Whether or not you give consent, Medi-Cal will continue to pay for medically necessary health-related services your child receives outside of school. Further, the district's participation in this program and your consent should not impact your child's benefits in any way.

4. How does the district use the funds received from Medicaid billing?

The district uses Medicaid funds to supplement the cost of the services being performed at school sites every day. In addition, these funds are used to support additional family outreach efforts, school health offices, updating testing equipment and materials, purchasing supplies, etc., in an effort to support all children in the district.

5. Will the district stop providing services for my child if I do not provide my consent to bill Medicaid?

No. Without your consent for billing, your child will continue to receive care but the district will not receive Medicaid funds for the eligible services that your child may be provided. Other district funds will be used to support the full cost of these necessary services.

6. What if I change my mind after I have already provided you with my consent?

You have the right to withdraw your consent at any time (a withdrawal will not be retroactive). See the front desk at your child's school if you'd like to make a change.

7. What information is shared, with whom, and what guarantees exist to ensure confidentiality of these records?

The education records that may be shared include: child's name and date of birth; health-related evaluation, intervention, and referral information (for services received at school); practitioners' notes related to these health services; and, select data from child's IEP/IFSP (if applicable). The district's reimbursement recovery vendor is bound by a contract that contains specific provisions to keep student records confidential and secure, ensuring information is not used or disclosed inappropriately; further, our vendor is HIPAA compliant. In addition, the district and DHCS are bound by agreements that include specific provisions about the use of the information shared in this program, and explicit security protocols to keep your child's information confidential and secure.