COLTON HEAD START

471 AGUA MANSA ROAD, COLTON 92324

(909) 841-5130

(909) 601-4952

PART DAY PROGRAM

Monday-Thursday

8:30am - 12:00pm or 12:30pm - 4:00pm

EXTENDED DAY PROGRAM

Monday - Friday

8:00AM - 2:00PM

ENROLL NOW







Play-based learning

Developmentally appropriate curriculum

Outdoor play

Please bring the following:

- Verification of Income “W-2's, Taxes, or Cash Aid”
- Child’s Birth Certificate
- Child’s Immunization Record
- Verification of Residence “Utility bill or post marked letter” (within 30 days of application date

MARIA.NEGRETE@SBCPSD.COM

IRENE.SIMMONS@SBCPSD.COM

PRESCHOOL SERVICES DEPARTMENT ENROLLMENT APPLICATION

CHILD'S INFORMATION			☐EHS –CCP ☐EHS ☐HS ☐LIFT/EHS
Child's Legal Name First	**Middle Initial**	**Last**	
Child's Place of Birth (City, State)		**Child's DOB (mm/dd/yyyy)**	**Sex:** ☐ Male ☐ Female
Child's Ethnicity Latino ☐ Yes ☐ No	**Child's Race**: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Multi/Bi-racial ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unspecified		
Child's Primary Language:		**Child's Secondary Language**:	
Parental Status: ☐ **One parent** ☐ **Two parents** ☐ **Foster parent(s)** ☐ **Guardian(s)**			

CHILD'S HOUSEHOLD/FAMILY INFORMATION				
1. Adult One Name (First/Last):	**Latino** ☐ Yes ☐ No	**Race**:	**Primary Language** (if different from child)	**Secondary Language** (if different from child)
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated		**Sex:** ☐ Male ☐ Female		
Date of Birth:	**Relationship to Child:**			
Education Level: ☐ **Grade _____** ☐ **High School Graduate** ☐ **GED** ☐ **Some College** ☐ **Associates Degree** ☐ **Bachelor's Degree or Higher**	**Employment:** ☐**FT** ☐ **PT** ☐ **N/A** **Income Source:** ☐ Employment ☐ Disability ☐ Unemployment Benefits ☐ Other		**School Training:** ☐**FT** ☐ **PT** ☐ **N/A**	
Residential Address:		**Mailing Address** (if different from residential address):		
Current Housing: ☐ Rent ☐ Own ☐ Homeless ☐ Other				
City:	**State**: **CA**	**Zip Code**:	**City**:	**State**: **Zip Code**:

2. Adult Two Name (if applicable)	**Latino** ☐ Yes ☐ No	**Race**:	
Date of Birth:	**Relationship to Child:**	**Sex:** ☐ Male ☐ Female	
Education Level:	**Employment:** ☐**FT** ☐ **PT** ☐ **N/A** **Income Source:** ☐ Employment ☐ Disability ☐ Unemployment Benefits ☐ Other	**School Training:** ☐**FT** ☐ **PT** ☐ **N/A**	
Primary Phone Number: ☐ Home ☐ Cell ( ) **Ok to Text?** ☐ Yes ☐ No		**Other Phone**: ☐ Home ☐ Cell ☐ Work ☐ Message ( ) **Ok to Text?** ☐ Yes ☐ No	
Email Address:	**Ok to Email?** ☐ Yes ☐ No	**Current Housing**: ☐ Rent ☐ Own ☐ Homeless ☐ Other	

INFORMATION	
Family Receives: CalWORKs ☐ Yes ☐ No Supplemental Security Income (SSI) ☐ Yes ☐ No	**Does Child Have Medical Insurance?** ☐ Yes ☐ No Check all that apply: ☐Medi-Cal ☐Private ☐Military ☐Tribal
	Does Child Have Dental Insurance? ☐ Yes ☐ No
Does the Family Receive WIC? ☐ Yes ☐ No	**Does the Family Receive CalFresh?** ☐ Yes ☐ No

How Did You Hear About Us? (Check all that apply): ☐ Community Event ☐ Flyer/Poster ☐ School District ☐ Other Preschool Program ☐ Facebook/Social Media ☐ Local Community Agency Referral ☐ Billboard ☐ Bus ☐Family Friend ☐ Online ☐Returning/Other Head Start Parent ☐ Other (please explain)

INFORMATION		
Are you currently Pregnant? ☐ Yes ☐ No If Yes, Expected Due Date:		
At least one parent/guardian is a member of the United States military on active duty ☐ Yes ☐ No		
At least one parent/guardian is a veteran of the United States military ☐ Yes ☐ No		
Some Head Start sites provide bus transportation. Will your child need transportation if available? ☐ Yes ☐ No If yes, explain why:		
Are you related to a PSD employee ☐Yes ☐ No		
Employee Name	Relationship to Child	Site

PRESCHOOL SERVICES DEPARTMENT ENROLLMENT APPLICATION

ADDITIONAL HOUSEHOLD INFORMATION

First & Last Name of Family Members in Home (Supported by parent/guardian)	Relationship to Applicant	Date of Birth	Sex	Race/Ethnicity	Employment
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Total Number in Family (Including Adults):

SPECIAL NEEDS

Children with diagnosed special needs may receive priority for Head Start enrollment (Disclosure of information is strictly voluntary)

1. Does your child have a disability ☐ Yes ☐ No ☐ I choose not to disclose (**If no go to #6**)
2. Type of special need/disability_____
3. Has the child's disability been professionally diagnosed? ☐ Yes ☐ No
   If yes, at what age?_____
   By whom?_____
4. Does the child have an IFSP/IEP? ☐ Yes ☐ No
5. Is the child receiving special services for their disability? ☐ Yes ☐ No
6. In your opinion, does your child have a special need that has not yet been diagnosed? ☐ Yes ☐ No
   If yes, please explain:

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Applicant Signature:	**Date:**

TO BE COMPLETED BY PSD STAFF

Initial Enrollment **Program Year:**	**Center Name:**	**Family ID:** **Child ID:**	**First Day Child Attended Class**(Entry):
Acceptance Status: ☐ Accept ☐ Deny	**Program Type:** ☐ EHS ☐ Head Start ☐ LIFT ☐ EHS -CCP		**Program Option:** ☐ Home Base ☐ Full Day ☐ Part Day

Income Eligibility (select one): ☐ Income (below FPL guidelines) ☐ Over Income **Documents Verified** (select all that apply): ☐ 1040 Taxes ☐ Check Stub ☐ W2 ☐ Written Statement from Employer ☐ UIB ☐ Document of no income ☐ Other: _____ **Total Annual Income**:$_____	**Categorical Eligibility** (select one): ☐ Homeless ☐ Foster Care ☐ CalWORKs ☐ SSI **Documents Verified** (select one): ☐ Foster placement papers ☐ Passport to Services ☐ NOA ☐ SSI Award Letter ☐ Statement from homeless service provider ☐ Other	**EHS –CCP Only:** CD 9600 date:_____ First date of subsidized service:_____

Birth Verified By: ☐ Birth Certificate ☐ Passport ☐ Foster Placement Papers ☐ Medi-Cal card ☐ Other	**Age by Enrollment Date:**	**Months at Time of Enrollment (EHS)**

Verifying CEU Staff Member (Print Name):	**Signature:**	**Date:**
Parent Signature (2nd Year) *Head Start Regulations [1302.12(i)(1)]*		**Date:**
Parent Signature (3rd Year EHS) *Head Start Regulations [1302.12(i)(1)]*		**Date:**

Notes:

☐ In Person Interview ☐ Phone Interview

Site Generalist Signature:	**Date:**

California Department of Education
December 2022

Management Bulletin 22-04(a) – Attachment A
Family Language Instrument

Purpose and Framing

The purpose of this instrument is to identify and understand each child's language background in order to support and strengthen their language development. When adults understand children's past experiences with language(s), they are able to build upon those experiences and better support children's development, by affirming and fostering the child's home language and culture to support them in becoming multilingual and multi-literate in both English and their home language(s).

This information will be used to inform and plan program curriculum, develop strategies used in the learning setting, create professional development opportunities, and to strengthen family partnerships to improve support for dual language learner (DLL) children.

Determinations made for preschool dual language learner status based on the results of this instrument are distinct from the English learner (EL) designation in the Transitional Kindergarten through 12th grade (TK-12) system. Dual language learner identification in preschool does not establish EL designation or secure EL services in TK-12. Students enrolled in TK-12 will need to go through the English learner identification process, including completion of their district's home language survey (HLS) and English Language Proficiency Assessments for California (ELPAC) upon entry to Transitional Kindergarten (TK) or Kindergarten, as required by state and federal law.

Instructions

California State Preschool (CSPP) contractors must follow the directives in Management Bulletin (MB) 22-04(a) when administering this instrument.

When providing the instrument, CSPP contractors can use the following language to reassure and address parents and families concerned about the implications of DLL identification in preschool and relationship to English learner status in TK-12:

- 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 receive as an English learner in Transitional Kindergarten or Kindergarten.

California Department of Education
December 2022

Family Language Instrument

1) **Which language(s) does your child hear at home?**
   This includes the language(s) 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?

National Center on
Health, Behavioral Health, and Safety

Head Start Oral Health Form—Children

Patient Information

Child's name | Date of birth | Parent's/guardian's name | Phone number

Address | City | State | Zip code

This practice is the child's dental home: ☐ Yes ○ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ○ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ○ No

Are there treatment needs? ☐ Yes, urgent ○ Yes, not urgent ○ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ○ No
X-rays: ☐ Yes ○ No
Risk assessment: ☐ Yes ○ No
Cleaning: ☐ Yes ○ No
Fluoride varnish: ☐ Yes ○ No
Dental sealants: ☐ Yes ○ No

Counseling/Anticipatory Guidance

☐ Yes ○ No

Referral to Specialty Care

☐ Yes ○ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ○ No
Silver diamine fluoride: ☐ Yes ○ No
Crowns: ☐ Yes ○ No
Extractions: ☐ Yes ○ No
Emergency care: ☐ Yes ○ No
Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ○ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ○ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

This resource is supported by the Administration for Children and Families (ACF) of the United States (U.S.) Department of Health and Human Services (HHS) as part of a financial assistance award totaling $8,200,000 with 100% funded by ACF. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, ACF/HHS or the U.S. Government.

Preschool Services Department

Consent Form

Child's Name _____ Site Colton Head Start

With your permission, a number of routine screenings will be performed while your child is enrolled in the Head Start, State Preschool, Early Head Start, or State Infant/Toddler Program. The purpose of these screenings is to assess the general health and development of your child and to identify any health and/or development concerns. If our screenings indicate that further evaluation, medical examination, or treatments are needed, we will contact you and will assist you in the follow-up process.

I give my permission to the San Bernardino County Preschool Services Department and to its contracted Community Partners to perform or obtain the following:

- Medical Authorization
- Vision Screening (Eyes)
- Hearing Screening (Hearing)
- Height/Weight Screening
- Blood Pressure
- Non-invasive Hemoglobin Screening
- Tooth brushing (with fluoride toothpaste)
- Dental Screening and Topical Fluoride Application
- Speech/Language Screening – Communication Profile
- Developmental Screening (Learning): ASQ 3
- Social/Emotional Screening: Ages & Stages (ASQ-SE)
- Psychological and/or Developmental Assessment (Behavior)
- Desired Results Developmental Profile and Assessment
- Home Visit Rating Scales (HOVRS – Home Base Program only)

_____ _____

Signature of Parent/Guardian Date

_____ _____

Staff Signature Date

SAN BERNARDINO COUNTY

Preschool Services Department

662 S. Tippecanoe Ave., San Bernardino, CA 92415

Child Nutrition Survey (2-5 Years)

Child Name: _____ DOB: (mm/dd/yyyy) _____

Center: Colton Head Start Date: _____

Nutrition Assessment	Yes	No
1. Does your child eat fruits & vegetables?		
2. Is your child a picky eater now?		
3. In the past six months, was your child found to be anemic (low blood iron)?		
4. Is your child involved in active play daily?		
5. Does your child have constipation frequently?		
6. Does your child drink from a baby bottle now?		
7. Does your child have difficulty chewing or swallowing now?		
8. Do you have concerns about your child's growth, nutrition or eating?		
9. Does your child participate in any Nutrition Programs? (please check all that apply) ☐ WIC ☐ Food Stamps ☐ WIC Value ☐ Other		

How often does your child eat these foods? Please write the number of times per day your child eats these foods.

Food Groups	**Number of Servings per day**
1. Milk Group: Milk (Whole, 2%, 1%, Skim) Yogurt, Cheese, Milkshakes)	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
2. Meat, Poultry, Fish, Dry Beans, Eggs: Beef, chicken, turkey, pork, fish, eggs, peanut butter, Nut group: dried beans, nuts, peas, lentils	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
3. Bread, Cereal, Rice & Pasta Group: Bread (all kinds), hot or cold cereal, crackers, tortillas, noodles or pasta (all kinds), rice	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
4. Vitamin C Rich Group: Oranges, Grapefruit, Lemons, Limes, Strawberries, Tangerine, Watermelon, Mangos, Tomatoes, Cabbage	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
5. Other Fruits & Vegetables Group: Apples, Banana, Pear, Grapes, Peaches, Potatoes, Green Beans, Corn	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
6. Vitamin A Rich Group (per week): Dark green or orange vegetables & fruits such as greens, carrots, broccoli, winter squash, spinach, pumpkin, sweet potato, apricots, canned plums, mangos	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7

SAN BERNARDINO COUNTY

Preschool Services Department

662 S. Tippecanoe Ave., San Bernardino, CA 92415

Child Nutrition Survey (2-5 Years)

How often does your child eat these foods per day? Circle the appropriate number.

7. Fatty Foods: a. Bacon, lunch meat, sausage, hot dogs, fried foods b. Butter/margarine, sour cream, regular salad dressings, mayonnaise	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7
8. Soda and Flavored Drinks such as Pop, Kool-Aid, fruit flavored drinks 9. Sugar and Sweets, such as cake, cookies, high-sugar cereals 10. Salty snacks such as chips, salted pretzels and pickles	0 * 1 * 2 * 3 * 4 * 5 * 6 * 7 0 * 1 * 2 * 3 * 4 * 5 * 6 * 7 0 * 1 * 2 * 3 * 4 * 5 * 6 * 7

Food Substitution(s)	**Yes**	**No**
1. Is your child restricted from foods due to religious, vegetarian, medical or personal beliefs? If yes, please specify: _____		
2. Does your child have any food allergies or intolerances? If yes, please specify:		
3. What kind of reaction does your child have when your child eats the specified food?		
4. Does your child need to have medication at school in case of an allergic reaction?		
5. Is your child on any special diet prescribed by a doctor? If yes, please specify:		

NOTE TO STAFF – If yes to questions 2, 3, and/or 5 above, Staff must give Physician's statement to parent. If yes to question 2, 4 above, Staff must have parents complete Food Allergy Questionnaire. Site supervisor must provide Medication Forms if parent(s) indicate the need for medication at school from food allergies.

NOTE: Substitutions for non-medical reasons (i.e. religious, vegetarian, etc.) will be approved on a case-by-case basis with the Nutrition Manager or Nutritionist. Substitutions for medical reasons will be accommodated only with a signed statement from a licensed physician or other medical authority.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

This Nutrition Survey should be updated yearly, using a new form.

SAN BERNARDINO COUNTY
Preschool Services Department

662 S. Tippecanoe Ave, San Bernardino, California, 92415-0630
(909) 383-2078 Fax (909) 383-2087

PERMISSION FOR RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____ Site: Colton Head Start

City: _____ Zip: _____Telephone: _____

I give Preschool Services Department of San Bernardino County permission to obtain from or give to the following persons or agencies pertinent medical, developmental, social or other information about my child. I understand that such information will remain confidential to all other parties and that information will be used only to give my child the best available professional services.

Name of Agencies and/or Person: (Include agency name, address, and phone number)

DR. Information

_____
Agency Name

_____
Address

_____
City/State/Zip

_____
Telephone Fax Number

Dental Information

_____
Agency Name

_____
Address

_____
City/State/Zip

_____
Telephone Fax Number

_____ _____
Parent/Guardian Signature Date Signed

This consent shall remain effective for one year following the date of signature. A copy of this is as valid as the original.

☐ I have received a copy of Parents' and Students' Rights.

_____ _____
Parent/Guardian Signature Date Signed

Agency Grievance Policy

The Preschool Services Department (PSD) of San Bernardino County operates the Federal Head Start and State Department of Education's State Preschool programs. PSD strives to be the very best in the services we provide to children and families. PSD encourages open communication between our staff and parents, community partners, and the communities we serve.

To assist our parents and those we serve to have a voice in the daily operations of the program, we provide parents and the community an avenue for submitting their concerns, feedback and/or compliments.

If you have concerns, we ask that all attempts are made to resolve them through direct feedback and problem solving with the staff and supervisors involved.

- If, attempts to resolve your concerns have been unsuccessful at this level, the following procedure will serve as a guide to address your concerns.
- This procedure may also be used to submit feedback and or compliments.

Procedure

1. Complete the Concern/Feedback/Compliment Form available at every site.
2. Written concern should include:
    - Name and address of the person filing the concern
    - A description of the problem
    - Date of occurrence
    - Names of people involved
    - Possible solutions
    - Parents should consult with their FCP Generalist or Site Supervisor for advice and assistance.
3. The form should be completed by the individual(s) involved and submitted to:

    Preschool Services Department
    Attn: Program Manager
    662 South Tippecanoe Avenue
    San Bernardino, CA 92415-0630
    (909) 383-2000

4. Upon receipt of a concern:
    - A meeting will be scheduled to discuss the situation;
    - The Program Manager may invite those concerned to attempt to resolve the concern;
    - The Program Manager will issue a written decision in response to the concern not later than 30 days from the date filing

Uniform Complaint Procedures

It is the intent of the PSD to fully comply with all applicable state and federal laws and regulations.

Individuals, agencies, organizations, students and interested third parties have the right to file a complaint regarding alleged violation of federal and/or state laws. This includes allegations of unlawful discrimination (ED Code sections 200 and 220 and Government Code section 11135) in any program or activity funded directly by the State or receiving federal or state financial assistance.

For State Preschool programs, complaints must be signed and filed in writing with the State Department of Education.

Child Development Division
Compliant Coordinator
1430 N. Street Suite 3410
Sacramento, CA 95814

If the complainant is not satisfied with the final written decision of the California Department of Education, remedies may be available in federal or state court. The complainant should seek the advice of an attorney of his/her choosing in this event.

A complainant filing a written complaint alleging violations of prohibited discrimination may also pursue civil law remedies, including, but not limited to, injunctions, restraining orders, or other remedies or orders.

The following documents are needed _____ in order to process your eligibility in the _____ (Head Start/ Early Head Start/State/LIFT/, etc.) program. Expect delays in your application approval if required documentation is not received by this date _____.

I wish to acknowledge that I received, read and understand the contents of the Preschool Services Department Agency Grievance Policy and Procedure.

Parent/Guardian Signature: _____ Date: _____

Center Based Generalist Signature: _____ Date: _____

Site: _____

Child's Name: _____

McKinney-Vento Assistance Act Parent Questionnaire

Please complete the following information about your housing. All information will be treated confidentially. No information will be shared with other agencies without your permission.

Name of Parent/Legal Guardian: _____

Date: _____

Name of enrolling child: _____

School: Colton Head Start

Where does the family currently live? Please check all that apply:

- ☐ Own a home
- ☐ Rent our home or apartment
- ☐ Live in California
- ☐ Live with others due to loss of housing, economic hardship, or similar reason
- ☐ Live in motels, hotels, trailer parks, campgrounds due to lack of alternative adequate accommodations
- ☐ Live in an emergency or transitional shelter or abandoned at the hospital
- ☐ Live in car, park, public spaces, abandoned buildings, substandard housing
- ☐ Live in bus or train station or similar setting
- ☐ None of the above. Please explain:

_____

_____

I declare under penalty of perjury the above information is true and correct to the best of my knowledge. If any part is false, my participation in the agency's program may be terminated. I also understand the information in this application will be held in strict confidence with the agency.

_____ _____

Parent/Guardian Signature Date

Family Strengths & Needs Assessment

Participant Name: _____ ChildPlus ID: _____

Date Completed: _____ Case Worker: _____ School Year: _____

Scoring Legend: 5.0 Empowered 2.0 Vulnerable

4.0 Building Capacity 1.0 Crisis

3.0 Stable

Assessment Item **Immediate Needs**	**Score**
Food	
1. Yes 2. No	
Clothing	
1. Yes 2. No	
Counseling	
1. Yes 2. No	
Health Concerns	
1. Yes 2. No	
Drug/Alcohol Abuse	
1. Yes 2. No	
Housing/Shelter	
1. Yes 2. No	
Utility Assistance	
1. Yes 2. No	
Domestic Violence	
1. Yes 2. No	
Child Abuse	
1. Yes 2. No	

Assessment Notes:

Family Strengths and Needs Assessments are to be completed once or twice a year depending on the date of enrollment. The FSA 1 is due within 30 days of the enrollment date. The FSA 2 is due 180 days from the enrollment date.

Are you and your child ready for high quality early learning at PSD? Great! There are a few items that we will need to get you started.

In order to be considered for the ***Head Start or Early Head Start Program*** we must receive the documents listed in the table in order for the program to determine your eligibility.

Please contact the Center Base Generalist if you have any questions or if you are unable to provide any documents listed in the table:

Check Submitted Documents	Documents
☐	**Enrollment Application (attached)**
☐	**McKinney-Vento Questionnaire** (attached)
☐	**Proof of Birth or Proof of Pregnancy** – enrolling child only Examples: • Birth Certificate • Baptismal Certificate • Medi-Cal Card • U.S. or International Passport • Certificate of Live Birth • Ultrasound/Sonogram (For Prenatal Program)
☐	**Proof of Residence in San Bernardino County** Examples: • Utility bill (dated within 30 days of application date) • Rental receipt (dated within 30 days of application date) • Rental agreement • Other _____
☐	**Income Documents (If applicable) – 12 months** Examples: • All W2's, Complete Tax Return or all 1099s • Pay Stubs for 12 months • Employer verification (form provided by PSD) • Supplemental Security Income (SSI) statement • Passport to Services from the Transitional Assistance Department (TAD) if receiving CalWORKS Cash Aid* **Automatically income eligible*
☐	**Foster Child or Homeless Family (automatically eligible for services)** Examples: • Foster documentation/letter from social service agency • 3rd party certification for homeless (form provided by PSD) • Letter from homeless shelter
☐	**Current immunization records**
☐	**Individual Educational Program (IEP) or Individual Family Service Plan (IFSP)**

Are you and your child ready for high quality early learning at PSD? Great! There are a few items that we will need to get you started.

In order to be considered for the ***Head Start or Early Head Start Program*** we must receive the documents listed in the table in order for the program to determine your eligibility.

Please contact the Center Base Generalist if you have any questions or if you are unable to provide any documents listed in the table:

Check Submitted Documents	Documents
☐	**CD 9600 – Application for Child Development Services** (attached)
☐	**CD 9600A – Child Care Data Collection Form** (attached)
☐	**McKinney-Vento Questionnaire** (attached)
☐	**Proof of Birth** (enrolling child and ***ALL*** siblings) Examples: • Birth Certificate • Baptismal Certificate • U.S. or International Passport • Certificate of Live Birth • Other _____
☐	**Proof of Residence in California** Examples: • Utility bill (dated within 30 days of application date) • Rental receipt (dated within 30 days of application date) • Rental agreement • Other _____
☐	**Income Documents** (If applicable) – **30 days minimum** Employer Verification Form is required if not self-employed (attached) Examples: • Pay Stubs (30 days preceding parents signature and date on 9600) • Employer verification (attached) • 1099 or signed tax returns for self-employed • Self-certification of income • Social Security statement
☐	**Automatically Eligible:** • **Child at Risk of Abuse or Neglect** • **Homeless Family** • **Cash Aid Recipient** Examples: • Referral from child welfare agency for childcare services *(dated within the 6 months of the application being submitted)* • 3rd party certification for homeless (form provided by PSD) • Letter from homeless shelter • Passport to Services from the Transitional Assistance Department (TAD) •
☐	**Current immunization records**
☐	**Proof of need – Full day services** Is required for each parent/guardian in the home Examples: • Employment hours* • Vocational training* • Seeking permanent housing for family stability (Not homeless) • Statement of incapacitation from a physician **Work/training hours can include travel and or study time when applicable*

Head Start – State Preschool – Early Head Start

Individualized Family Partnership Agreement Form

1. Agency Name	2. Site/Classroom	3. Date
	Colton Head Start	
4. Child's Name (Last Name, First Name)	5. Parent/Guardian Name (Last Name, First Name)	
6. Phone Number	7. Email Address	

8. Family Goal Setting 1304.40 (a)(2)
I am/we are ready to participate in the Individualized Family Partnership Agreement ☐ Yes ☐ No
9. Family Goal #1
10. Referrals/Resources/Community Agency Name(s) to assist in achieving goal

11. Steps/Strategies	12. Target Date	13a. Date Follow up done (for each step)	13b. Check if parent completed Step	14. Responsible Party
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
DOTS REPRESENTING THE NUMBERS			☐	

15. Date IFPA Closed _____	16. The Family Goal Aligns with the Following Family Engagement Outcomes	17. The Family Goal Aligns with the Following School Readiness Goal
Overall Progress 1. ☐ Initial efforts toward achieving goal (25%) 2. ☐ Goal partially achieved (50%) 3. ☐ Goal near achievement (75%) 4. ☐ Goal achieved (100%)	1. ☐ Family Well Being 2. ☐ Positive Parent Child Relationships 3. ☐ Families as Lifelong Educators 4. ☐ Families as Learners 5. ☐ Family Engagement in Transitions 6. ☐ Families as Advocates and Leaders	1. ☐ Social Emotional 2. ☐ Language and Literacy 3. ☐ English Language Development 4. ☐ Approaches to Learning 5. ☐ Cognitive and General Knowledge 6. ☐ Physical Health Development

18. Home-based option: Parent/Guardian Role in Home Visit: 1304.40(a)(2) (e.g.: Learner, Teacher, Planner):

19. Parent/Guardian Role in Socializations: 1304.40(a)(2)/1306.33(b) (e.g.: Observer, Learner, Area Facilitator, Parent Group Leader):

20. Home Base Parent/Guardian Initials indicates that sections 18 & 19 have been reviewed with the parent. Initials _____ Date____

21. Parent/Guardian Signature _____ 22. Date _____

23. Family Advocate Signature _____24. Date _____

1. Agency Name	Enter the name of your Early Head Start/Head Start program
2. Site/Classroom	Enter the name of the child/pregnant woman site/classroom or home-based designation
3. Date	Enter date (MM/DD/YY) that staff initiated this form
4. Child Name	Enter Last Name, First Name of eligible child/pregnant woman
5. Parent/Guardian Name	Enter Last Name, First Name of the parent/guardian
6. Phone Number	Enter phone number
7. Email Address	Enter email address and if parent does not have email address indicate N/A
8. Family Goal Setting	Inquire about the parent/family interest in participating in an Individualized Family Partnership Agreement, Coaching may be required. A need identified under the Family Assessment may serve as a goal, a child's IEP/IFSP, a parent/guardian wishing to volunteer, or assistance on a pre-existing goal. Parent/Guardian may check they are ready or they are not ready. If yes, complete the steps for the Family Goal and add event into Child Plus. Include date event entered on IFPA form (See number 22 and 23 on IFPA form). If using a pre-existing plan for the family goal, please obtain a copy of the pre-existing plan, Utilize the pre-existing plan to create goals that help support the parent to the complete goals they are currently working on. If no, have the parent/guardian sign at the bottom of the form where a signature is requested if their child is part of a center-based option (Family Child Care) and write N/A on questions 14-16 and complete 17-23. If the child is part of a home-based model, questions 14-23 need to be completed. If the parent/guardian declines to participate in the Individualized Family Partnership Agreement, please write that the parent/guardian is not ready to participate in IFPA under the Family Partnership Notes section in Child Plus. Family/parent/guardian must be engaged one more time during the school year (60 days before the last day of school) if they are not ready to participate during the 1st attempt. ***Signature is not required from family member if goal is developed when family is re-engaged or if family member declines to develop a goal the second time.***
9. Family Goal #1	Identify a goal the parent/guardian hopes or intends to attain. This may be the same goal as listed on the Family Assessment a revised version or a brand new goal. This entry depends totally on the parent/guardian response. An Event must be entered in Child Plus for the Family Goal.
10. Referrals/Resources/Community Agency	Enter the name of the referral, resource, organization, or individual that will assist the family to attain goal(s). Staff must document provision of resources, but need not follow up on resources. Staff must be able to differentiate between a need identified (a referral) and an interest identified (a resource) by communicating with the family. Action needs to be added under the Event in Child Plus for any resource, referral, organization, or individual that was given to the family to assist in attaining the goal
11. Actions Steps/Strategies	Indicate the steps, strategies, or plans the parent/guardian will initiate to ultimately help him/her attain the goal. Parents may need staff assistance to help identify and list specific strategies that will lead to goal attainment. Please write more than one action or strategy. They should be attainable, realistic, and/or provide a roadmap to assist the family in achieving the goal.
12. Target Date	Indicate the date (MM/DD/YYYY) when the parent/guardian will take action regarding the strategy/action.
13. a. Date Follow Up Done b. Check box if parent Completed Step	13a) Indicate the follow-up date (MM/DD/YYYY) of when you have followed up with the parent on their action steps/strategies. 13b) Check box if parent completed action steps/strategies and leave box blank if no action was completed. ***Add actions (on Child Plus) to align with each follow-up and document in detail how the family is progressing or if there are any barriers to achieving the goal. Staff must document the family's efforts toward goal. Don't just state that you followed up. What happened?***
14. Responsible Party	Enter the parent/guardian who identified the goal
15. Date IFPA Closed	Write the close out date (MM/DD/YYYY). Check the outcome box of the overall progress of the Family Goal. 1. No effort at achieving goal, 2. Initial efforts toward achieving goal, 3. Some progress toward achieving goal, 4. Goal partially achieved, 5. Goal achieved. Once the IFPA has been officially closed, FA must re-engage parent for a new goal. Documentation must be indicated in Child Plus.
16. The Family Goals Aligns with PFCE Outcomes	Check the Parent and Family Community Engagement Outcome(s) that align with the Family Goal
17. The Family Goals Aligns with School Readiness Goal	Check the School Readiness Goal(s) that aligns with the Family Goal
18. Parent/Guardian Role in Home Visits	Review of the parent/guardian role in home visits for the home-based option is mandated by the Office of Head Start (OHS). Indicate the general parent/guardian role in home visits, which are listed here. More specific information will be discussed with the parent/guardian later by the assigned home visitor
19. Parent/Guardian Role in Socializations	Review of the parent/guardian role in socializations for the home-based option is mandated by OHS. Indicate the general parent/guardian role in socializations, which are listed here. More specific information will be discussed with the parent/guardian later by the assigned home visitor.
20. Parent/Guardian Initials	Parent/guardian initials and enters the date. This indicates that staff reviewed the general parent/guardian roles with the parent/guardian. Write N/A if the child is part of a center-based option
21. Parent/Guardian Signature	Parent/guardian signs the form even if he/she declined the opportunity to establish a goal. As stated earlier, signature by the parent/guardian is not required when a family member is re-engaged.
22. Date	Have parent enter date (MM/DD/YY) completed form was signed
23. Family Advocate Signature	The individual staff member who assisted the parent/guardian in completing this form signs
24. Date	The individual staff member who signed completed form enters the date (MM/DD/YY)

COUNTY OF SAN BERNARDINO
PRESCHOOL SERVICES DEPARTMENT
662 Tippecanoe Ave., San Bernardino, CA 92415-0630
(909) 383-2000 Fax (909) 383-2100

Child Health Record **MEDICAL HISTORY PROFILE (MHP)** **CENTER: Colton Head Start**

Date _____ Date of Birth: _____ (mm/dd/yyyy)

Child's First Name: _____ Gender: _____

Child's Middle Initial: _____ Enrollment Date: _____

Child's Last Name: _____

Birth History

Was the child born more than (3) three weeks early or late? (circle one) Yes No
If yes, please indicate how many weeks early _____ or late _____

Child's birth weight _____ Length at birth _____

Did baby or mother have problems in the hospital? Yes No If yes, please explain _____

Family History

Has any immediate family member (blood relation) had serious illnesses or abnormalities (e.g. asthma, cancer, convulsion, diabetes, heart disease, inherited disease, mental illness, other) ☐ No ☐ Yes Please explain:

Child's Medical History

Has the child ever had any of the following conditions? (Please check all that apply)

☐ Allergies	☐ Anemia	☐ Asthma
☐ Bleeding Conditions	☐ Cancer	☐ Hives
☐ Diabetes	☐ Eczema	☐ High Blood Pressure
☐ Heart Conditions	☐ High Lead	☐ Seizures (if yes Explain:_____
☐ Immune System Disease	☐ Liver Disease	
☐ Mental Retardation	☐ Mental Illness	☐ Tubes in Ears
☐ Sickle Cell Disease	☐ Sickle Cell Trait	
☐ Other		

Is your child receiving treatment for any of the following conditions? (Please check all that apply)
☐ Anemia ☐ Asthma ☐ Over/Underweight ☐ Hearing Difficulties ☐ Vision Problems

Is your child currently taking any medication? (A special consent form must be completed and signed for your child to receive any medication while at the Head Start program)
Name of medication: _____ Dosage: _____ How often?: _____

If your child has a health problem has it been diagnosed by a health care professional? Yes No
If yes please explain: _____
Include name and address of Doctor/Specialist: _____

Has your child had surgery? Yes No If yes please explain _____

Has your child ever been diagnosed with asthma? Yes No If yes: How often?_____ Cause _____ Date_____
If yes, has your child ever been hospitalized for asthma? When? _____ Intensive care (ICU/PICU)? Yes No

Has your child ever had an allergic reaction to ☐ food ☐ medicine ☐ insects ☐ other If yes, To what? _____
Explain reaction:

Does your child have any of the following conditions: (Please check all that apply and give dates and explain)

☐ Frequent Ear Infections	☐ Frequent Sore Throats	☐ Frequent Bed-Wetting	☐ Frequent Fevers
☐ Frequent Coughs	☐ Frequent Chest Pains	☐ Frequent Colds	☐ Frequent Stomach Ache
☐ Problems with Urine	☐ Problems with Bowels	☐ Problems Eating	☐ Problems with Teeth
☐ Problems Hearing	☐ Problems with Seeing	☐ Eye Problems	☐ Frequent Trouble Sleeping
☐ Speech Problems	☐ Temper Tantrums	☐ Other Frequent Problems _____	

Does your child have any additional conditions that interfere with his/her daily activities? Yes No
If yes, please explain: _____

If your child does not require medication at school parent please sign here: _____

Please turn over for additional questions.

Child's Activity History

Does your child currently have an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? Yes No
If yes, what school district completed the IEP/IFSP? _____

Children learn at different ages. To help Head Start assess your child's developmental level please complete the following chart
At what age did your child do the following activities:

Activity	Age	Activity	Age
Sit-up without help		Use the toilet	
Crawl	_____	Understand things being said	
Walk	_____	to him/her	_____
Talk	_____	Follow simple directions	_____
Feed and dress self	_____	Play with toys	_____
Use crayons			

Health Care Providers

Do you have a regular doctor for your child? Yes No If yes you must fill out completely

Doctor's Name

Doctor's Address

Doctor's Phone #

Do you need a referral for a doctor? Yes No (For office use only), generalist initial here if answer is yes _____

Do you have a regular dentist for your child? Yes No If yes you must fill out completely

Dentist's Name

Dentist's Address

Dentist's Phone #

Do you need a referral for a dentist? Yes No (For office use only), generalist initial here if answer is yes _____

Has your child had a professional dental exam within a year? Yes No If yes, please give copy to generalist

Is your child receiving preventative dental care? Yes No

Does your child need dental treatment? Yes No

Behavioral Health

Does your child's behavior concern you? Yes No If yes, please explain your concerns _____

Describe the behavior that your child displays?

How long does the behavior last?

How long has the behavior been occurring?

Thank you and please sign below.

Parent/Guardian Signature : _____ Date: _____

Staff Signature: _____ Date: _____

REPEATER CHILD:

Parents DO NOT sign below, the generalist will have you sign when the next school year begins. No changes in the medical history profile for the child's second year. Parent initial here: _____
If there are changes, please request a new MHP and fill it out accordingly, then attach it to the original MHP.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

COUNTY OF SAN BERNARDINO PRESCHOOL SERVICES

662 S. Tippecanoe Ave., San Bernardino, Ca 92415-0630 Phone: (909) 383-2078 Fax: (909) 383-2100

HEAD START/STATE PRESCHOOL CHILD HEALTH RECORD

Name:	D.O.B.:	Sex:	Center: **Colton Head Start**
Address:	City:	Zip:	Phone:
Parent(s)/Guardian:			

PHYSICAL EXAM

1.	HEIGHT: Inches	□ NORMAL □ DEVIATION	(Must mark if normal or deviation)
2.	WEIGHT: Pounds: BMI:	□ NORMAL □ DEVIATION	(Must mark if normal or deviation)
3.	BLOOD PRESSURE:		
SENSORY SCREENINGS			
4.	VISION SCREEN: R EYE: 20/	L EYE: 20/	BOTH EYES: 20/
5.	AUDIOMETRIC HEARING SCREEN: R EAR:	PASS/REFER	L EAR: PASS/REFER

TO BE FILLED IN BY HEALTH EXAMINER:		**NORMAL**	**DEVIATION FROM NORMAL (Give Details)**
6.	Skin		
7.	Eyes		
8.	Ears		
9.	Nose & Throat		
10.	Oral/Teeth		
11.	Glands		
12.	Lungs		
13.	Heart		
14.	Genitalia		
15.	Extremities		
16.	Posture & Gait		
17.	Developmental Surveillance		
18.	Psychosocial/Behavioral Assessment		
19.	General Maturity		
20.	Nutrition Assessment		

MEDICATIONS/ALLERGIES		
21.	Rx Taken Regularly:	
22.	Allergies:	
23.	Food Allergies: Date:	
ANEMIA AND LEAD SCREENING		
24.	Hemoglobin Risk Factor Assessment: □ Risk Factors NOT present □ Risk factors present, requires hemoglobin test	
	HEMOGLOBIN TEST: Date: _____ HGB: _____ HCT: _____Please indicate follow up required:	
25.	Blood Lead Risk Factor Assessment: □ Risk Factors NOT present □ Risk Factors present, requires blood lead test	
	BLOOD LEAD TEST: : Date: _____ Results: _____	
TUBERCULOSIS SCREENING		
26.	TB Risk Assessment: SCREENING OF TB RISK FACTORS: □ Risk Factors not present, TB test not required	
	TB MANTOUX TEST RESULT: □ Neg □ Pos ____mm (if positive complete CXR)	Date given: _____ Date read: _____
	CXR RESULT: □ Neg □ Pos Free of Communicable Disease: □ Yes □ No	CXR Exam Date:
	□ Follow-up needed:	
IMMUNIZATIONS		
27.	IMMUNIZATIONS (To be enrolled in Preschool, immunizations must be up to date for age as required by California State Law: 3 Polio, 4 DTaP, 3 Hep B, 1 Varicella, 1 MMR given on or after the first birthday, and at least 1 Hib given on or after the first birthday)	
	Immunizations Given Today: □ Polio □ DTaP □ Hep B □ Varicella □ MMR	
	Date next immunizations due:	
UP TO DATE		
28.	Child is up-to-date for age under the EPSDT Periodicity Schedule: □ Yes □ No	
29.	Child is current and up to date with immunizations for age: □ Yes □ No	

□ PHYSICAL EXAMINATION AND/OR HEALTH RECORD REVEALED NO CONDITION RELEVANT TO THE SCHOOL PROGRAM CHILD MAY PARTICIPATE IN ALL PRESCHOOL ACTIVITIES

□ CONDITIONS REVEALED WHICH ARE IMPORTANT TO SCHOOL OR PHYSICAL ACTIVITY ARE: *(Please note any limitations or restrictions)*

PLEASE INDICATE IF YOU ARE A C.H.D.P. PROVIDER: □ No □ Yes (if using a PM 160, please provide a copy to the parent)

Signature of Health Examiner Date of Exam License # Address Telephone

For San Bernardino County PSD Staff use

Date Received & Initials:

Colton Joint Unified School District

Frank Miranda, Ed,D., Superintendent

2025-2026 School Year

Dear Parent or Guardian,

The California Longitudinal Pupil Achievement Data System (CALPADS) requires each school to provide demographic information to meet compliance requirements delineated in the Every Student Succeeds Act (ESSA) Act of 2015. Parent education level is one component the state requires schools to collect as part of this program.

This information will be kept strictly confidential and will only be used to complete the state required reports.
Please provide the information below and submit this form with your registration packet.
We appreciate your help in this matter.

Sincerely,

Frank Miranda, Ed.D., Superintendent Colton Joint Unified School District

---

Please print the name of your son/daughter: _____
In the boxes below, indicate the highest education level achieved by each parent or guardian of this student:

Mother's Education Level

___ Not a high school graduate

___ High school graduate

___ Some college (this does not include vocational or Technical Certification)

___ College graduate (this means graduation with a B.A. or B.S. degree or an equivalent degree from a foreign university)

___ Graduate school/post graduate training

___ Decline to state or unknown

Father's Education Level

___ Not a high school graduate

___ High school graduate

___ Some college (this does not include vocational or Technical Certification)

___ College graduate (this means graduation with a B.A. or B.S. degree or an equivalent degree from a foreign university)

___ Graduate school/post graduate training

___ Decline to state or unknown

Name of Parent/Guardian Completing This Form (please print) _____

Parent/Guardian's Signature _____ Date: _____/_____/_____

Please advise school site administration of any changes to the above information.

COLTON JOINT UNIFIED SCHOOL DISTRICT

Student Registration Card

Grades TK-12th

Please complete form using BLACK ink and answer ALL questions.

Office use only: Grade: Student ID: School: Special Education Services ☐ YES ☐ NO

STUDENT'S INFORMATION: PLEASE PRINT BELOW – STUDENT'S LEGAL NAME *(name as it appears on the birth certificate)*

Legal Last Name:	**Legal First Name:**	**Legal Middle Name:**	(Circle one) AKA Nickname
Grade: **Age:**	**Birthdate:**	**Gender:** Female ☐ Non-binary ☐ Male ☐	**Student Contact #: ( )** Student cell ☐ Parent Cell ☐ Home Phone ☐

Student's Home Address: **City:** **Zip:**

FEDERAL RACE AND ETHNICITY DATA COLLECTION

The U.S. Department of Education requires all states to collect information on the race and ethnicity of public school students and staff. It allows students to be identified in more than one racial category. Please assist us in meeting this state requirement by answering the two questions below.

Ethnicity: Is this student Hispanic or Latino: (Select Only One) ❑ **No,** not Hispanic or Latino
❑ **Yes,** Hispanic or Latino

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:
❑Black or African American ❑White(origins in Europe, North Africa or Middle East) ❑American Indian or Alaska Native(origins in North, Central or South America) ❑Asian Indian ❑Asian-Other ❑Cambodian ❑Chinese ❑Japanese ❑Korean ❑Laotian ❑Vietnamese ❑Filipino ❑Guamanian ❑Hawaiian ❑Other Pacific Islander ❑Samoan ❑Tahitian

Is your student participating in any of the following programs? If yes, please check those that apply below:

Special Education

_____ Resource Specialist (RSP)
_____ Special Day Class Mild Moderate (SDC MM)
_____ Special Day Class Moderate Severe (SDC MS)
_____ Adaptive Physical Education (APE)
_____ Visually Impaired Program
_____ Speech/Language Program
_____ Other (Please list) Date of Last IEP:_____
(Please provide a copy of most recent IEP)

Program Participation

_____ English Learner (Level _____)
_____ Initial Fluent English (I-FEP)
_____ Redesignated Fluent English Proficiency (R-FEP)
LAC Testing Date: _____
_____ Gifted and Talented Education (GATE)
_____ AVID
_____ Designated 504 Plan
_____ Dual Immersion

Previous Schools Attended: Please list any schools your student attended previously, beginning with the most recent:

School: _____ District/City_____ State:_____ Dates Attended:____/____/_____ to ____/____/_____ Grade:_____

School: _____ District/City_____ State:_____ Dates Attended:____/____/_____ to ____/____/_____ Grade:_____

Has your student ever been suspended? ❑ Yes ❑ No If Yes, Grade Level:_____ Year:_____ School:_____

Has your student ever been expelled? ❑ Yes ❑ No If Yes, Grade Level:_____ Year:_____ School:_____

Is your student currently under an expulsion order, or been recommended for expulsion from a previous school district(s)? ❑ Yes ❑ No

Has Student Been Retained? ❑ Yes ❑ No If Yes, Grade Level:_____ Year:_____ School:_____

Parent/Legal Guardian/Caregiver enrolling student with whom the student lives with on a day to day basis:

Last Name:	**First Name:**	**Relationship to Student:**	☐ Lives with ☐ Not in the home

Primary Phone: ( ) Other Contact #: ( )
☐ Home ☐ Cell (receive text messages ☐)

Home Address:	Apt. # / Space:	City:	State: Zip Code:

Employer:	Address:	Work Phone #: ( )

Last Name:	**First Name:**	**Relationship to Student:**	☐ Lives with ☐ Not in the home

Primary Phone: ( ) Other Contact #: ( )
☐ Home ☐ Cell (receive text messages ☐)

Home Address:	Apt. # / Space:	City:	State: Zip Code:

Employer:	Address:	Work Phone #: ( )

1. Parent/Guardianship Information (with whom the student lives with on a day-to-day basis) – check all that apply.

❑Father ❑Mother ❑Both ❑Step-Father ❑Step-Mother ❑Court-appointed Guardian ❑Foster/Group Home ❑Caregiver-Caregiver Affidavit needed

2. Is the above (checked) person(s) the student's LEGAL guardian?❑Yes ❑No **If No, please complete a "Caregiver Affidavit"**

3. If there is a legal custody agreement or court order regarding this student, please check one:❑Joint Custody ❑Sole Custody ❑Guardian ❑Court Order

Who has legal/physical custody? _____ *Note: (Please provide court documents during time of enrollment to enforce custody orders, copies will remain in student's file, any modifications by the court thereafter are also required.)*

4. Does student have a Social/Probation/Welfare Worker?❑Yes ❑No If yes, Name: _____

Phone: (____) _____

5. If student currently under Foster Care, who holds student's educational rights? _____

6. Duplicate Mailings-If divorced/separated and joint custody allows duplicate mailing information to be given to other parent, please complete their information below.

Name:_____ Mailing Address:_____

City: State: Zip:

I certify that the information provided by me on this form are true and correct.

Parent(s)/Guardian Signature: _____ *Date:* _____

Office Use Only

School No._____ Enrollment Date: _____ Date CUM Requested: _____ CUM Requested from: _____
Placement determined by: ❑Overflow ❑ Inter District Transfer ❑ Intra District Transfer ❑ PPS Placed
Home School/District:_____ to: _____
Address Verification: ❑Utility/Rent Receipt ❑Two forms of correspondence ❑Student Residency Affidavit ❑Other_____
Legal Bindings: ❑Court Custody Orders ❑Restraining Order- duration of order *(place copy of all Legal bindings in CUM, enter legal binding on Q)*
Immunization Complete: ❑Yes ❑No Medical Exemption: ❑Yes ❑No First Grade Physical Date:_____ Waiver: ❑Yes ❑No
Birth Verification: ❑Yes ❑No ❑Birth certificate ❑Passport ❑Baptismal certificate duly attested ❑Affidavit ❑Other _____
Birth place: _____

City: State: Country:

Class Assignment: 1st Semester: _____ 2nd Semester: _____ School-Year: _____

Course Number	Section Number	Grade Level	Teacher	Room Number

Counselor Signature: _____ Date: _____
Enrollment Staff Signature: _____ Date: _____
Notes:

COLTON JOINT UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION FORM

Please fill in the information requested completely and accurately

(OFFICE USE ONLY) DATE:_____TEACHER:_____GRADE_____ STUDENT ID#_____

Student's Information

Last Name	First Name	Middle Name

Grade:	Birthdate:	Gender: ☐M ☐F ☐ Non-binary	Student Contact #: ☐ Student Cell ☐Parent Cell ☐Home Phone ☐ Student may receive text message notifications

STUDENT'S HOME ADDRESS:

ADDRESS CITY ZIP CODE

STUDENT'S MAILING ADDRESS **(IF DIFFERENT FROM ABOVE)**

Parent/Legal Guardian/Caregiver enrolling student with whom the student lives with on a day to day basis:

PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT: Live with student ☐
Home Address:	**Apt #** **City:**	State: Zip:
EMPLOYER: Address: WORK PH#:	PRIMARY PH#_____ EMAIL ADDRESS:	CELL PH# _____ Receive text messages ☐

PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT: Live with student ☐
HOME ADDRESS:	**Apt #** **City:**	State: Zip:
EMPLOYER: Address: WORK PH#	PRIMARY PH#_____ EMAIL ADDRESS:	CELL PH# _____ Receive text messages ☐

EMERGENCY CONTACTS

In case the school is **unable to reach** parent/legal guardian/caregiver the following responsible adults may be contacted in case of an emergency or disaster. Person must be 18 years or older with a valid contact number.

Emergency contact #1

First/Last Name: _____ **Contact #:** _____

Relationship:

Emergency contact #2

First/Last Name: _____ **Contact #:** _____

Relationship:

Emergency contact #3

First/Last Name: _____ **Contact #:** _____

Relationship:

COLTON JOINT UNIFIED SCHOOL DISTRICT

STUDENT EMERGENCY INFORMATION FORM (continued)

Please fill in the information requested completely and accurately:

UNITED STATES ARMED FORCES

Is either parent/guardian on **Active Duty** in the Armed Forces or National Reserve:

yes ☐ no ☐ If yes, date started:

Is other parent/guardian on Full-time National Guard Duty:

yes ☐ no ☐ If yes, date started:

Pregnant/Parent Student

Is the student currently pregnant or expecting?

yes☐ no☐ If yes, due date:_____

Is the student a parent?

yes☐ no☐ If yes, age of child:_____

Names of siblings in District and/or in the Home:

Name:_____ School:_____ dob:_____

Name:_____ School:_____ dob:_____

Name:_____ School:_____ dob:_____

Name:_____ School:_____ dob:_____

Student Health History: Please read and check any illnesses or conditions your child has. Write/list health conditions, medications, explanations of any checked condition under the "comments" section.

☐ No known Health Problems
☐ Serious accidents or hospitalizations
☐ Allergies:_____
☐ Asthma
☐ ADHD/ADD
☐ Autism
☐ Birth defects/Genetic disorders
☐ Blood/bleeding disorders
☐ Cerebral Palsy
☐ Cancer/Leukemia
☐ Diabetes Yes No
Insulin dependent: Yes No
☐ Dietary restrictions:_____
_____
☐ Heart problems/heart surgery
☐ Epilepsy/seizures
Type of seizures:_____
Date of last seizure:_____

Comments:

☐ Hearing loss: right left
Hearing aids: yes no
☐ Kidney disorder/bladder problems
☐ Transplant:_____
☐ Psychological concerns –
(ex. Anxiety, Depression, etc.)
Diagnosis:_____
☐ Vision impairment
☐ Requires "specialized health procedure".
Explain under "comments".
☐ Other

My child takes the following medications at school:

Health Plan/Insurance Co. Group Policy #:

My child takes the following medications at home:

Daytime Ph#: Address:

Family Doctor:

The undersigned parent/guardian certifies that the information provided above is correct and accurate.

Print Parent/Legal Guardian/Caregiver Name	Signature	Date