



STATE PRESCHOOL PROGRAM

Dear Parents,

Thank you for choosing to enroll your child in our preschool program. We are funded by the California Department of Education and regulated by Title 5 and licensed by Community Childcare Licensing Title 22 therefore, our 3 hours (7:50-10:50 or 12-3) services are provided to families who meet income guidelines or Family Fee Service. Please provide the **originals** of the following documents to determine eligibility. The application is a legal document and must be completed in **BLUE INK (no pencil)** and **SIGNED**, thereby attesting under penalty of perjury these documents are true and correct.

Please Note:

- If you have any questions regarding this packet, call from 7:30am – 4:00pm.
- Once you **COMPLETE** the application, **PLEASE call 310-680-3500** to schedule an appointment. No exceptions.
- Only the parent or guardian may submit the application. Please provide any form of identification card.
- If your application is incomplete, it will be returned to you and you will need to return for another appointment.

Documents to bring the day of your appointment:

☐	1. Family Adjusted Gross Monthly Income Title 5, Section 18086 For accurate monthly, (30-day preceding appointment date), income verification provide one of the following: • If you receive biweekly checks, you must provide 2 recent consecutive check stubs (within a month). • If you receive weekly checks, you must provide 4 recent consecutive check stubs (within a month). • You must provide verification stating grant amount if you receive any of the following: *Cal Works *TANF *AFDC *SSI *Disability *Worker's Comp *Unemployment *etc... • If Self Employed, provide a combination of documents such as, letter from the source of income, copy of the most recently signed completed quarterly tax return with a statement of current estimated income, business record, ledgers, or receipts. • If you are a Day Laborer, please pick up a form prior to your appointment.
☐	2. Address Verifications (2 Proofs – within 30 days) LSD Board Policy #5111 & Title 22 • The following documents are acceptable: Property tax payment receipts. Utility service contract, statement, or payment receipts. Paystubs, Voter registration. Correspondence from a government agency. Declaration of residency executed by the parent or legal guardian of a pupil. • Rental Agreement is accepted, (Names, address, date) Rent receipts will NOT be accepted. If you do not live in the Lennox School District, we will provide a permit application.
☐	3. Family Size LSD Board Policy 48002 Title 22 Please bring one of the following documents for every child under 18 years of age in your home that you financially support: • Birth Certificate(s) • Adoption document(s) • Records of Foster Care Court orders regarding child custody • Other reliable documentation
☐	4. Physician's report: Doctor's signature, stamped & dated Title 22 • Hearing and vision examination • Development delays or speech concerns • Documentation of any other concerns, i.e.: seizures, asthma, allergies, etc... • If your child has a current IFSP or IEP provide a copy
☐ NOTA: Requerido para empezar y continuar	5. Child's Immunization Record LSD Board Policy 5141.31 Title 22 Must have the following: • 3 Polio • 4 DTP/DtaP/Dtp • 3 Hepatitis B • 1 Varicella • Prueba de TB Tuberculosis Skin Test: If the doctor determines the child is not at risk, a TB skin test is not necessary but must be noted on physician's report. • TB Test (Within a year) The following must be given on or after the first birthday: • 1 MMR • 1 Hib
	6. PARTICIPATING ADULTS provide: Title 22 • TB Test within a year • MMR • DTAP • FLU
☐	7. Provide any form of identification card for parent

Parent Orientation upon completion

Pre-K Registration



Where children play, sing, and learn!

The lack of compliance with these requirements may delay your child's enrollment!

INCOME CEILING TO QUALIFY FOR STATE PRESCHOOL

In order to qualify for State Preschool Part-Day services, families must be at or below 80% of the State Median Income (SMI) to enrolling a CDE/CDD-contracted program. The table below delineates the monthly and annual income ceilings by family size used to determine their eligibility for enrollment in a program contracted by the CDE/CDD. If your income is lower than the shaded column, your child qualifies for preschool. If your income exceeds the table guidelines and you live in Lennox school boundaries, still call and schedule and enrollment appointment.

Schedule of Income Ceilings for the State Preschool Program 2024-2025				
QUALIFY			15% (Qualify)	
Family Size	Monthly	Yearly	Monthly	Yearly
1 to 2	\$7,209	\$86,514	\$8,291	\$99,492
3	\$8,154	\$97,843	\$9,377	\$112,524
4	\$9,441	\$113,292	\$10,857	\$130,284
5	\$10,952	\$131,419	\$12,594	\$151,128
6	\$12,462	\$149,546	\$14,331	\$171,972
7	\$12,745	\$152,944	\$14,657	\$175,884
8	\$13,029	\$156,343	\$14,983	\$179,796
9	\$13,312	\$159,742	\$15,309	\$183,708
10	\$13,595	\$163,141	\$15,634	\$187,608
11	\$13,878	\$166,539	\$15,960	\$191,520
12	\$14,162	\$169,938	\$16,286	\$195,432

Rev August, 2023

If you do not qualify based on income and you live in the Lennox School District State Preschool Program boundaries you can still attend our program! Turn in your application and income.

Enrollment Dates for Children 0-5 years old

If your child is going to be 3, 4 or 5 years old what program does he/she qualify for...?

<u>Date of Birth</u>	<u>Program</u>
September 2, 2019 – December 1, 2021	Preschool

Note: You may enroll in Preschool as soon as the child turns three.

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS / FAMILY CHILD CARE HOMES

To be completed by Parent or Authorized Representative



Child's Information:			
First Middle Last		Gender ☐ Female ☐ Male	Birth date
Birth City Birth State Birth Country		Hispanic: Circle one ☐ YES ☐ NO	Parent Email
Street Address City State Zip Code		Telephone Number: ()	
Father's Information: ☐ Biological ☐ Step Father ☐ Domestic Partner			
First Middle Last Name		Birth Date	Cell Phone ()
Work Place	Work Address		Business Phone ()
Mother's Information: ☐ Biological ☐ Step Mother ☐ Domestic Partner			
First Middle Last Name		Last Birth date	Cell Phone ()
Work Place	Work Address		Business Phone ()
Parent's Education			
Father's Education Level (Check one). ☐ Not a High School Graduate ☐ Some College ☐ Decline to State ☐ High School Graduate ☐ College Graduate		Mother's Education Level (Check one) ☐ Not a High School Graduate ☐ Some College ☐ Decline to State ☐ High School Graduate ☐ College Graduate	
ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY (DO NOT ADD PARENT) (*Must provide at least a minimum of 3 emergency contacts (not counting parents) with address and telephone number) NAMES OF PERSON AUTHORIZED TO TAKE CHILD FROM THE FACILITY (Contacts must be 18 years or older and present Photo ID) (Child will not be released to anyone without authorization on this form from parent or guardian)			
Name shown on Identification Card	Address	Telephone	Relationship to child
*			
*			
*			
PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY (Please complete this section and do not leave anything blank)			
Physician and Address		Medical Plan & Number	Telephone Number ()
Dentist and Address		Medical Plan & Number	Telephone Number ()
If Physician cannot be reached, what actions should be taken? ☐ CALL EMERGENCY HOSPITAL ☐ OTHER Explain:			
Signature of parent or guardian _____ Date _____			For Office Only
			Publicity Release ☐ Yes ☐ No
TO BE COMPLETED BY AUTHORIZED REPRESENTATIVE			
DATE OF ADMISSION:		DATE LEFT:	



CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME		GENDER ☐ M ☐ F		DATE OF BIRTH	
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD? If not, documentation is required. ☐ YES ☐ NO			
MOTHER'S NAME		¿ DOES MOTHER LIVE IN HOME WITH CHILD? If not, documentation is required. ☐ YES ☐ NO			
GUARDIAN'S NAME		IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? ☐ SI ☐ NO		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION? Within 1 year of enrollment.	
DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)					
WALKED AT* YEARS MONTHS		BEGAN TALKING AT* YEARS MONTHS		TOILET TRAINING STARTED AT* YEARS MONTHS	
PAST ILLNESSES – Check illnesses that child has had and specify approximate dates of illnesses					
☐ Chicken Pox ☐ Asthma ☐ Rheumatic Fever ☐ Hay Fever		DATES ☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Mumps		DATES ☐ Poliomyelitis ☐ Ten-Day Measles (Rubeola) ☐ Three-Day Measles ☐ (Rubella)	
SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS					
LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF			DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO		HOW MANY IN LAST YEAR?
RUTINA DIARIA (*solamente para los bebés y niños de edad preescolar)					
WHAT TIME DOES CHILD GET UP? *		WHAT TIME DOES CHILD GO TO BED? *		DOES CHILD SLEEP WELL? * ☐ YES ☐ NO	
DOES CHILD SLEEP DURING THE DAY?		WHEN*		HOW LONG?	
PATRÓN DE DIETA (¿Qué come el niño usualmente para estas comidas?)  BREAKFAST _____ LUNCH _____ DINNER _____				WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____ 	
ANY FOOD DISLIKES?			ANY EATING PROBLEMS?		
IS CHILD TOILET TRAINED? If not, inform teacher and provide pull-ups & wipes. ☐ YES ☐ NO		IF YES, AT WHAT STAGE: *		ARE BOWEL MOVEMENTS REGULAR? * ☐ YES ☐ NO	
WORD USED FOR "BOWEL MOVEMENT"*		WHAT IS USUAL TIME?*			
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 OF SIDE EFFECTS:		DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ 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 _____					

FAMILY LANGUAGE INSTRUMENT

Child's Name: _____

Date: _____

Form completed by (check one) ☐ Mother ☐ Father ☐ Legal Guardian

Identification of your child as a dual language learner in California State Preschool Program (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.

- 1). Which language(s) does your child hear at home? _____
- 2). Which language(s) does your child hear in their neighborhood and community? _____
- 3). Which language(s) does your child understand? _____
- 4). Which language(s) does your child speak? _____

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)

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?

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.)

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

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

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.)

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?

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:



HEALTH AND SOCIAL SERVICE NEEDS

Date: _____

Child's Name: _____ School: _____

Parent's Names: _____

Address: _____

Telephone Number: _____ Alternative Number: _____

Number in household: _____ Languages other than English in home: _____

1. Do you need information or referrals in any of the following areas: (Check all that apply)

Food Assistance – St. Margaret's	Family Counseling – Didi Hirsch, Richstone	Nutrition
Housing	Parenting Education/Information -	Crisis Intervention
Home Buyer's Assistance	GED Information	Gang/Crime Prevention
Dental Referral	ESL/Citizenship Information	Naturalization
Employment Training	Employment	Transportation
After School Program - LEAP	Legal Assistance	Health/Immunization
Clothing – St. Vincent de Paul's	Tutoring	Medical/Insurance
Recreational Activities	Counseling	Other:
Anti-Substance Abuse Training	Emergency Housing	
Has your child attended other programs (i.e.: West Regional center, Carousel? If so which program(s)? Provide supporting documentation		

2. Parent Workshop Survey: (Select topics of interest):

Literacy	Discipline	Language Acquisition
Importance of Play	Nutrition/Health	Speech and Language
Child Development	School Readiness	Conflict Resolution
Preschool Foundations	Curriculum: High Scope	Desired Results (Academic Progress)

3. Parent Workshop Meeting Times and Days: Select the best meeting time and day)

8:30 AM	11:00 AM	3:15 PM	Monday	Wednesday	Friday
5:00 PM	6:00 PM	Otro:	Tuesday	Thursday	Saturday



Parent's / Guardian's Signature _____

Date _____

FOR OFFICE USE ONLY

Action Taken: _____

Date: _____

Follow Up: : _____

Date: _____

- ☐ Data inputted in Care Control
- ☐ If counseling selected in section 1, send to Director of Special Education
- ☐ If child attended Early Head Start, WRC or other program/services, request supporting documentation
- ☐ Share with Staff as needed: _____



Lennox School District

STUDENT NIGHTTIME RESIDENCY QUESTIONNAIRE

10319 Firmona Ave. Lennox, CA, 90304
Tel. (310) 695-4000 Fax (310) 671-1795

This questionnaire is intended to address the McKinney-Vento Act, U.S.C.A Section 11302(a). Your answers will help the school determine residency documents necessary for enrollment and services to which you may be eligible.

Date: _____ School: _____ Student ID# _____

Student Name (First, MI, Last: _____ ☐ Male ☐ Female

Date of Birth: _____ Grade: PREK Special Ed: ☐ NO ☐ YES, designation _____

Address: _____ City: _____ Zip: _____

Mailing Address (if different): _____

Parent/Guardian Name: _____ Contact Number: _____

The student(s) live(s) with: ☐ 1 parent ☐ 1 parent & another adult ☐ an adult that is not the parent/guardian
☐ 2 parents ☐ a relative ☐ alone with no adults

Student's Living Situation (Check all that may apply):

- ☐ (100) In a shelter _____ (name of shelter)

☐ (110) In a motel or hotel _____ (name of motel/hotel)

☐ (210) In a transitional housing program _____ (name of program)

☐ (130) In a car, trailer or campsite, **temporarily, due to inadequate housing**

☐ (130) In a rented trailer/motor home on private property

☐ (120) In a Single Room Occupancy (SRO) building – a multiple tenant building consisting of individual rooms with shared restrooms and kitchens

☐ (130) In a rented garage, **temporarily, due to loss of housing**

☐ (120) In another family's house or apartment, **temporarily, due to loss of housing**, stemming from financial problems (e.g. loss of job, eviction, or natural disasters)

☐ (120) With an adult that is not the parent/legal guardian, **temporarily, due to loss of housing**

☐ (130) Other places not designed for, or ordinarily used as a regular sleeping accommodation for human beings
(please explain) _____

☐ Living alone, without any adult (unaccompanied youth)

☐ **None of the above apply** – NO FURTHER INFORMATION REQUIRED AT THIS TIME. IF YOUR HOUSING SITUATION CHANGES, PLEASE NOTIFY YOUR CHILD'S SCHOOL.

Please list all siblings between the ages of birth and 22 years old.

NAME	DOB	AGE	GRADE	SCHOOL

By signing this form, I declare under penalty of the laws in the State of California that the foregoing is true and correct. In addition, I understand that the District reserves the right to verify and above listed residence information.

Signature of Parent/Legal Guardian/Caregiver: _____ Date: _____

VERIFICATION OF RESIDENCY IN LENNOX SCHOOL DISTRICT

SECTION 4219.1 of the Inglewood Municipal Code read as follows:

It shall be unlawful for any person to willfully make any false or misleading statement, either verbal or written, to any officer or employee of any school district within the City for the purpose of obtaining enrollment in such school district for any person.

Any violation of the Section shall be a misdemeanor and shall be punishable by a fine of not more than Five Hundred Dollars (\$500), or by imprisonment in the City or County Jail for a period not exceeding six months, or by both such fine and imprisonment.

I, _____, the parent or guardian of _____ am seeking to enroll
Parent's Name Child's Name
him/her in _____ Preschool and I certify under penalties of perjury, that the above-named school-
School
aged child, actually lives at _____
Address
and our telephone number is (_____) _____ which is located at the above address.
Phone #

Signature

Relationship to enrollee

Date

TO BE COMPLETED BY SCHOOL ENROLLING OFFICER

Two of the following verifications have been accepted as proof of Lennox School District Residency (EC 48204.1, 48200, 4820). Reasonable evidence or residency for a pupil living with his or her parent or legal guardian shall be established by documentation showing the name and address of the parent or legal guardian within the school district, but not limited to, any of the following documentation:

	(1) Property tax payment receipts
	(2) Rental property contract or lease
	(3) Utility service contract, statement, or payment receipts.
	(4) Pay stubs.
	(5) Voter registration.
	(6) Correspondence from a government agency.
	(7) Declaration of residency executed by the parent or legal guardian of a pupil.

Enrolling Officer

School

Date



PARENT COMMITMENT TO PARTICIPATE IN A DUAL LANGUAGE PROGRAM

STUDENT NAME	DATE OF BIRTH	SCHOOL

If you wish your child to participate in the Dual Language Program, please complete this sheet.

☐ NO, I DO NOT WISH TO PARTICIPATE IN THE DUAL LANGUAGE PROGRAM MODEL.

50/50 Dual Language Program Model

The Lennox School District Dual Language program is a simultaneous language acquisition program. It is a 50/50 Spanish/English program that will alternate in language of instruction based on the daily schedule and teacher model(s).

Program Description (Parents must initial each line)

I understand that my child will receive instruction in **English** and **Spanish** in all subject areas.

Parent's initial

I agree that I will remain committed to the Dual Language Program throughout my child's preschool years.

Parent's initial

I will support my child's educational development by:

1. Making sure my child maintains a good attendance record.
2. Making myself available to volunteer in the classroom or school every year.
3. Reading to my child daily.

Parent's initial

I understand that both **English** and **Spanish** instructional materials will be used.

Parent's initial

I understand that the goals for my child are:

1. To become bilingual, biliterate, bicultural
2. To succeed academically
3. To develop appreciation of and respect for other cultures

Parent's initial

If I have any questions, I know to speak with my child's teacher, the Site Supervisor or contact the Director of State Preschool.

Parent's initial

I have reviewed and understand the program contract and expectations.

PARENT'S NAME	ELECTRONIC PARENT' SIGNATURE	DATE



READ WITH ME

Parent Commitment Form



I, along with my child, will participate in the Families In School's Read With Me program. I understand that I will receive a backpack, filled with up to ten books. As a participant in the program, I promise to:

★	Read to my child every day, preferable for 20 minutes each day.
★	Return the backpack to school upon request.
★	Return the backpack and books in good condition.
★	If I leave the program, I will return the backpack and all books to the school.
★	If the backpack or any of its contents are lost or damaged, I understand that I am responsible for replacing any materials or paying (\$80) to have them replaced.
★	Only use the backpack for its intended purpose.

Parent's Name: _____

Parent's Signature: _____

Child's Name: _____

Teacher: _____



Families In School mission is to involve parents and communities in their children's education to achieve lifelong success. Document may be photocopied for local school use.

**CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers or Family Child Care Homes**

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

School's 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 _____. THIS CARE MAY BE GIVEN UNDER WHATEVER
Child's Name
CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

Child has the following medication allergies:



Parent's / Guardian's Signature

Date

Address

Home Phone Number

Cell Phone Number

Work Phone Number



Eligibility Verification Notice / Aviso de Verificación de Elegibilidad

Date: _____

Parent/Guardian's Name: _____

Child's Name: _____

School: _____

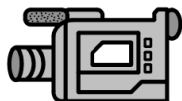
The Lennox State Preschool is required by the California Department of Education (CDE) Child Development Division (CDD) to determine a family's eligibility to receive state preschool services based on family size, income, or child protective services status. The use or disclosure of individual financial information concerning enrollees or their families will be limited to purposes connected with the administration of child care and development programs. The uses of this information include, but is not limited to contact employers, medical or legal professionals, social workers, and/or other institutions or persons, in order to verify family eligibility.

Any fraudulent, false, incomplete, deceitful, or misleading information provided to Lennox State Preschool regarding status of income or family size, that is used to determine initial eligibility, may be grounds for termination of state preschool services. Lennox State Preschool is required to recover costs from the parents or guardian for state preschool services at the time of initial enrollment.

I understand that Lennox State Preschool has the right to verify information presented for the purpose of determining eligibility to receive state preschool services.

Parent's Signature: _____ Date: _____

Agency Representative: _____ Date: _____



Publication Release Form

Lennox School District



During the school year, your student may have the opportunity to have his/her photograph(s) and/or schoolwork published in the district, school, and/or local news publications, and/or displayed on the district/school Web sites and social media accounts (District Instagram, Facebook, or Twitter accounts). Publishing or displaying student photographs and schoolwork furthers the school's educational mission and permits you, the parent or guardian, along with other friends or relatives of the child, to view your child's accomplishments.

Please check one:

- ☐ Yes, I give permission to allow my child to be photographed/videotaped and to use his/her first name in publications.
- ☐ No, I do not give permission to allow my child to be photographed/videotaped and to use his/her first name in publications.

Child's name: _____

School: _____

School Year: _____

Parent/Guardian's Name: _____

Firma del padre: _____ Fecha: _____

Please note that if your child participated in public events (such as a sporting event or drama production that is open to the community) the school/district may have little or no control over photographs taken by media, other parents, or community members attending the events.

OFFICE USE ONLY:

Information updated in Powerschool by _____
Staff Name

Date entered in Powerschool _____

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. [We have an open door policy.](#)
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. Complain to the licensing office and inspect the family child care home without discrimination or retaliation against you or your child.
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: El Segundo Regional Office
Licensing Office Address: 300 N Continental Blvd Suite 290A, El Segundo, CA 90245
Licensing Office Telephone #: 424-301-3077

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 FAMILY CHILD CARE HOME 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 "FAMILY CHILD CARE HOME
Child's Name
NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER
AWARENESS INFORMATION form from the licensee.

Buford Felton Jefferson Moffett Whelan
Name of Family Child Care Home/School (Circle one)

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

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. **We refrain from religious instruction.**
- (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		
El Segundo Regional Office		
ADDRESS		
300 N Continental Blvd Suite 290A, El Segundo, CA 90245		
CITY	ZIP CODE	PHONE
424-301-3077		

DETACH HERE



TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights 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:

(CIRCLE THE NAME OF THE FACILITY)

- ☐ Buford State Preschool
☐ Felton State Preschool
☐ Jefferson State Preschool
☐ Moffett State Preschool
☐ Whelan State Preschool

(CHECK THE ADDRESS OF THE FACILITY)

- ☐ Buford: 10915 Felton Avenue
☐ Felton: 10417 Felton Avenue
☐ Jefferson: 10203 Firmona Avenue
☐ Moffett: 11050 Larch Avenue
☐ Whelan: 4125 105th Street

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

☐ Mother ☐ Father ☐ Guardian

(DATE)

Release Authorization of Employment



I, _____ authorize Lennox School District State Preschool
Program to verify employment from by employer.

Employer

Address

Telephone

Hours of operation
Paid every
☐ week ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Work Schedule	
Sunday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Monday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Tuesday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Wednesday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Thursday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Friday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Saturday:	_____ ☐ am ☐ pm - _____ ☐ am ☐ pm
Date Hired: _____	

Parent's Signature

Date

For Office Use Only

Date: _____ Time: _____ Initial: _____ Spoke with: _____ Notes: _____

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Parent's Signature

Date

For Office Use Only

Date: _____ Time: _____ Initial: _____ Spoke with: _____ Notes: _____



Lennox School District
State Preschool Program

10203 Firmona Avenue, Lennox, CA 90304 310-680-3500 Fax 310-330-4910



PARTICIPATING PARENTS, GUARDIANS or VOLUNTEERS HEALTH REQUIREMENTS
PADRES, TUTORES O VOLUNTARIOS PARTICIPANTES REQUISITOS DE SALUD

All volunteers at Lennox School District State Preschool Program must maintain the following health requirements.

Todos los voluntarios del Programa Preescolar Estatal de Lennox deben mantener los siguientes requisitos de salud.

Adult's Name/Nombre del Adulto		School /Escuela
Child's Name/Nombre del niño		Telephone Number/Numero de teléfono
Address/Dirección		
Medical Provider/Proveedor de servicios medicos	Provider's Number/Numero de teléfono	Provider's Fax Number/Numero de fax

I authorize the medical provider listed above to release the following medical information to Lennox School District State Preschool Program./ Autorizo al proveedor médico mencionado arriba para que divulgue la siguiente información médica al Programa Preescolar Estatal de Lennox.

Parent/Volunteer's Signature/Firma del Padre o Voluntario

TO BE COMPLETED BY MEDICAL PROVIDER

Tuberculosis Requirement (prior to start date and updated every 2 years or 4 years for X Rays)

Date Given	Date Read	☐ Positive	☐ Negative	Results mm
Date of Chest X-Ray		☐ Normal	☐ Abnormal	RX-Date

Medical Provider's Signature

Influenza Requirement

☐ Flu vaccination date _____

Medical Provider's Signature

☐ I have declined to be vaccinated against the flu/
He rechazado vacunarme contra la gripe

Adult's Signature

Pertussis Requirement

☐ Immunization date _____
☐ Volunteer/parent is already immune to pertussis documentation attached

Medical Provider's Signature

Medical Provider

Form completed by: _____

☐ Physician ☐ Physician's Asst. ☐ Nurse Practitioner

Signature: _____

Date: _____



Measles Requirement

- ☐ Volunteer born before 1957
- ☐ Immunization date _____
- ☐ Volunteer/parent is already immune to Measles documentation attached

Medical Provider's Signature

TO BE COMPLETED IN THE PRESCHOOL OFFICE

Child's Name: _____

I decline volunteering in my child's classroom. I also know that I will not be able to attend school functions such as, Mommy and Me, Daddy and Me, Trikeathon, Jogathon, etc..., that are in the classroom due to not having vaccinations. If I do want to volunteer I know that I have to submit the vaccinations to the Preschool office.

Parent's Signature and Date

Nombre del Niño: _____

Rechazo el trabajo voluntario en la escuela de mi hijo/a. También estoy consiente de que no podré asistir a las funciones escolares tales como, Mamá y Yo, Papá y Yo, Triciclón, etc., que están en el aula debido a que no entregue mis vacunas. Si quiero ser voluntario, sé que tengo que llevar las vacunas a la oficina preescolar.

Firma de Padre/Madre y Fecha

To be completed by Preschool Office

- ☐ TB Test
- ☐ Flu
- ☐ MMR
- ☐ TDAP
- ☐ Copy in Health File
- ☐ Copy in Teacher File
- ☐ Copy in Vaccination Folder

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

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

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Allergies: medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)	/ /	/ /			
HIB MENINGITIS (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