



Folsom Cordova Unified School District

California State Preschool Program (CSPP)

2460 Cordova Lane, Rancho Cordova, CA 95670

916.294.9090 Fax 916.294.2474

Student Enrollment Process

To ensure smooth and timely enrollment, please follow the steps outlined below:

Step 1: Obtain an Enrollment Application

- Visit the Cordova Lane Office to pick up the official enrollment application packet.

Step 2: Gather Required Documentation

- Collect all necessary documents as listed in the **first section** of the application packet.
Please review the list carefully—missing documentation may result in processing delays.

Step 3: Schedule an Appointment

- Contact our office at **(916) 294-9090, ext. 610116** to schedule an enrollment appointment.

Step 4: Complete Online Registration (InfoSnap)

- Submit the InfoSnap online registration form.
- Upload or provide **any additional required documents** not previously submitted.

Step 5: Await Notice of Action

- Once all required steps and documentation have been completed, a **Notice of Action** will be issued to confirm enrollment status.

****Important: Incomplete applications or missing documents may delay the enrollment process. Please ensure all steps are followed and all materials are submitted in a timely manner.**



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2026/2027 Preschool Enrollment Application

Thank you for your interest in California State Preschool Program (CSPP). We look forward to partnering with you to enroll your child(ren) in our program. If you meet age and income qualifications, fill out this application in its entirety and collect all necessary documents. (See reverse side for enrollment specifications and details.)

Most application materials can now be submitted electronically (InfoSnap). However, some forms requiring original signatures are included in this packet and must be completed and submitted in person, along with all required documents, at the time of your scheduled appointment.

Required Documents Submitted from Every Family:

- **Birth Certificate (s)**- Proof of birth for ALL children 18 and younger in the family.
- **Proof of Family Income** for 30 days prior to your appointment.
- **Physician's Report**- Child Care Center Health Evaluation sheet signed and dated within the last 12 months by your Physician's Office, Including a TB screen or Test.
- **Immunization Record**- Yellow CA Immunization Record Card or official print out from clinic. Child will not be enrolled if shots are not up to date.
- **Proof of Residency**- Recent SMUD, PG&E, or Rental Agreement showing Parent Name and Physical Address of the home. **(IF YOU RESIDE WITH SOMEONE, please bring Affidavit of Residency with Proof of Residency. Speak with office for more information if this applies to your situation.)**
- **Ages & Stages Questionnaire**- Two-part questionnaire, **ASQ-3 & ASQ:SE-2**, completed on the following website:

<http://asqonline.com/family/5792dd>

If Applicable to Your Family Situation Submit:

- Non-Income Form
- If your child takes medicine or has allergies, please ask office staff for a separate form.
- Court-Ordered Custody arrangement documentation
- IEP- Individualized Education Plan

Families are eligible for CSPP *IF*

1. The child's date of birth falls between 9/02/2021 and 12/02/2023 or when the child turns 3, **AND**
2. Income does not exceed the State Medium Income (SMI.) Refer to the Family Income Guidelines chart below for income ceilings.

Family Income Guidelines*			
Family Size	Gross Family Monthly Income	Family Size	Maximum Gross Family Monthly Income**
1-2	\$ 8,376	1-2	\$ 9,632
3	\$9,476	3	\$10,897
4	\$11,337	4	\$13,038
5	\$13,151	5	\$15,124
6	\$14,965	6	\$17,210
7	\$15,305	7	\$17,601
8	\$15,645	8	\$17,992
9	\$15,985	9	\$18,383
10	\$16,325	10	\$18,774
11	\$16,665	11	\$19,165
12+	\$17,006	12+	\$19,556
*SMI guidelines are waived if the child's homeschool is qualified Free Reduced Paid Meals (FRPM). (FRPM schools include: Cordova Meadows, Cordova Villa, White Rock, & Williamson.)			
**10% of families enrolled can earn above the Gross Family Monthly Income threshold not to exceed the Maximum Gross Family Monthly Income.			

PRESCHOOL SITES/TIMES LISTED BELOW. Times and locations may have limited availability, please circle your preferred class time, and indicate your top 3 schools of choice in order of preference.

Morning Classes are 8:00-11:00 AM | Afternoon Classes are 11:45-2:45 PM

Rancho Cordova:

AM PM ____ Cordova Gardens, 2400 Dawes St.
 AM PM ____ Cordova Lane, 2460 Cordova Lane
 AM PM ____ Cordova Meadows, 2550 La Loma Dr.
 AM PM ____ Cordova Villa, 10460 Reymouth Ave.
 AM PM ____ Rancho Cordova, 2562 Chassella Way
 AM ____ Peter J Shields, 10434 Georgetown Dr.
 AM PM ____ White Rock, 10487 White Rock Rd.
 AM PM ____ Williamson, 2275 Benita Dr.

Folsom:

AM PM ____ Theodore Judah Preschool, 101 Dean Way

Important Placement Information:

Site and time requests are considered when children are accepted. Preschool office staff determine placement based on eligibility of family, age health needs, and program necessity. If your child is not accepted at your requested site or time, you may turn down the placement and ask to have your child placed on the waiting list for the requested site and time.

Note: Enrollment is **not** on a first come basis. Program qualifications are based on age, monthly income, and family size-children under protective services and four-year-olds have priority. *The submission of this enrollment packet **does not** guarantee enrollment within FCUSD's Preschool Program.* FCUSD also offers concurrent enrollment of Preschool and Transitional Kindergarten for four- year-olds.

For more information or questions regarding eligibility contact Sonia Davis at sdavis@fcusd.org or Call 916.294.9090 ext. 610116

FAMILY INFORMATION:

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced

If divorced, do both parents share custody?

☐

Yes

☐

No

Please Explain: _____

PRIMARY LANGUAGE SPOKEN:

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WORK/ SCHOOL STATUS:

☐ Employed ☐ Self Employed ☐ Homemaker
☐ Unemployed ☐ Disabled ☐ Student

Employer/ School Name & Address:

Employer/School Phone Number: _____

WORK/ SCHOOL STATUS:

☐ Employed ☐ Self Employed ☐ Homemaker
☐ Unemployed ☐ Disabled ☐ Student

Employer/ School Name & Address:

Employer/School Phone Number: _____

Gross Monthly Income (before taxes) \$ _____

CalWorks Cash Aid: \$ _____ Cal Fresh: \$ _____

Housing Assistance: \$ _____ Other Aid: \$ _____

Child Support: \$ _____ Spousal Support: \$ _____

Disability: \$ _____ Workers Compensation: \$ _____

TANF/Cash Aid: \$ _____ Adoption Asst.: \$ _____

Foster Grant: \$ _____ Cal Fresh: \$ _____

Work for Cash: \$ _____ Other Income: \$ _____

Gross Monthly Income (before taxes): \$ _____

CalWorks Cash Aid: \$ _____ Cal Fresh: \$ _____

Housing Assistance: \$ _____ Other Aid: \$ _____

Child Support: \$ _____ Spousal Support: \$ _____

Disability: \$ _____ Workers Compensation: \$ _____

TANF/Cash Aid: \$ _____ Adoption Asst.: \$ _____

Foster Grant: \$ _____ Cal Fresh: \$ _____

Work for Cash: \$ _____ Other Income: \$ _____

Fraud: Knowingly or intentionally making false statements or presenting false information, as a means of obtaining state funded preschool services constitutes fraud. Information will be submitted to the district attorney for prosecution and the family may be liable for repayment of state preschool funds.

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Parent A Signature:

Date:

Parent B Signature:

Date:



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AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

PARENT/ LEGAL GUARDIAN A: EMPLOYER INFORMATION

_____ Company Name	_____ Contact Name	_____ Telephone
_____ Company Street Address	_____ City	_____ Zip Code
_____ Company Business hours		

EMPLOYEE STATEMENT OF RELEASE:

Folsom Cordova Unified School District representatives have permission to contact my employer to verify my income & employment information to determine my family eligibility during the certification process. I understand all information gathered is solely confidential.

_____ Print Parent/ Legal Guardian Name	_____ Parent/Legal Guardian Signature	_____ Date
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PARENT/ LEGAL GUARDIAN B: EMPLOYER INFORMATION

_____ Company Name	_____ Contact Name	_____ Telephone
_____ Company Street Address	_____ City	_____ Zip Code
_____ Company Business hours		

EMPLOYEE STATEMENT OF RELEASE:

Folsom Cordova Unified School District representatives have permission to contact my employer to verify my income & employment information to determine my family eligibility during the certification process. I understand all information gathered is solely confidential.

_____ Print Parent/ Legal Guardian Name	_____ Parent/Legal Guardian Signature	_____ Date
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FOR OFFICE PURPOSES ONLY

Verification Notes: _____

Date Verification: _____ Verified with: _____ Staff initials: _____



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SELF DECLARATION OF ZERO INCOME

PARENT/GUARDIAN NAME: _____

CHILD'S NAME: _____

1. I hereby certify that I do not individually receive income from any of the following sources in the last 30 days:
 - a. Wages from employment (including commissions, tips, bonuses, fees, etc.);
 - b. Income from operation of a business;
 - c. Rental income from real or personal property;
 - d. Interest or dividends from assets;
 - e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
 - f. Unemployment or disability payments;
 - g. Public assistance payments;
 - h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household;
 - i. Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc.);
 - j. Any other source not named above.

2. Please check one of the following:

☐ Currently, I have no income of any kind and while I am seeking employment, there is no definite job offer at this time.

☐ Currently, I have no income of any kind and I will not be seeking employment at this time.

I understand that FCUSD has the right to verify information presented for the purposes of determining eligibility to receive subsidized preschool services.

Parent/Guardian Signature: _____ **Date:** _____

Fraud:

Knowingly or intentionally making false statements or presenting false information as a means of obtaining state funded preschool services constitutes fraud. Information will be submitted to the district attorney for prosecution and the family may be liable for repayment of state preschool funds.

Child's Name: _____ Parent/Guardian Name(s): _____

2026/2027 TERMS OF ENROLLMENT FCUSD PRESCHOOL PROGRAMS

Initial each line after you have carefully read each term of enrollment. Both Parent/Guardians must sign if applicable.

_____ I understand it is my responsibility to provide all eligibility documentation to the Preschool office.

_____ I understand it is my responsibility to attend the Preschool Parent Orientation, held before school starts and I will follow the rules and policies of the California State Preschool Program (CSPP), which are included in the Handbook that will be given to me at Initial enrollment or Parent Orientation.

_____ I understand I must attend a fall parent/teacher conference and three Parent Information Meetings/Parent Chats given throughout the year.

_____ I understand my child's immunizations must be current: 3- Polio, 4 -DTaP, 1-Varicella, 1-MMR &Hib (on or after 1st Birthday) and 3- Hepatitis B. These immunizations are mandatory. Personal belief exemptions will no longer be accepted per Senate Bill 277.

_____ I understand that I need to be readily available if my child is not fully potty trained for accidents.

A toilet-trained child is a child who can do the following:

1. Tell an adult they need to use the bathroom BEFORE they must go.
2. Pull down their pants and underwear and get them back up without assistance.
3. Wipe themselves after using the toilet.
4. Get on and off the toilet without assistance.
5. Wash and dry hands.
6. Go directly back to the activities without directions.
7. Able to postpone going if they must wait for someone who is in the bathroom or if we are outside.

Due to health regulations and facility limitations, our staff is not licensed to change children. If a child has an accident, they need to be able to fully clean and change themselves OR a plan will need to be in place to have your child changed. If your child has a medical reason and is not toilet trained, please provide a signed and stamped note from your doctor.

_____ I understand I am required to notify the program office **immediately** with any changes to address, telephone, and emergency card updates.

_____ I understand **only** persons **18 years of age or older** and whose names I have indicated on my child's district enrollment/emergency card may sign my child in or out from preschool **using their full legal signature** and identification will be requested at any time for anyone picking up children.

_____ I understand my child must be well enough to participate in the normal activities of the Preschool Program including outdoor play, if they are not, I must keep them home. I will call the preschool site to notify them of my child's absence.

_____ Daily attendance will help your child develop a sense of trust and security during their preschool experience. I understand my child may be dropped from the program for irregular attendance totaling 15 days of unexcused absences.

_____ I understand if my child has been absent for 30 consecutive days and I have had no contact with the teacher, known as "Abandonment of Care," a letter will be mailed as the final method of contact before a notice of termination will be mailed.

- _____ Late pick up disrupts staff work schedules and may jeopardize program mandated adult/child ratios.
I understand it is my responsibility to find alternative transportation for my child in such circumstances that prohibit me from on time arrival, and notify the teacher if such an occasion arises.
- _____ I understand my child may be disenrolled from the program for causing injury to another child or staff member or has behavior that poses a threat to the physical or emotional well-being of other children or staff.
- _____ I understand my child may be disenrolled from the program if I, or another designated adult, violate California Penal Code Section 71 regarding the threatening of public officer, employees, and school officials.
- _____ I will give at least a 1 week notice to my child's teacher and CSPP office staff if I am withdrawing my child from preschool, and I will be asked to sign a "Notice of Withdrawal" prior to exiting the program.
- _____ In the event of a family emergency, health reasons, or other justifiable personal reasons, I may sign a "Request Time Off" form from CSPP to temporarily excuse prolonged absences.
- _____ I understand I must advise the Preschool staff of any special needs including but not limited to food allergies, health/medical concerns, individualized education plans (IEP), and 504 plans.
- _____ I understand siblings and other children not enrolled in the preschool program are not permitted in the classroom when I volunteer or any other days that class is in session.
- _____ I understand in order to volunteer in the classroom, FCUSD requires me to complete a volunteer packet, have a current TB test on file and be fingerprinted.
- _____ I understand the use or disclosure of all information pertaining to the child and his/her family shall be restricted to the purposes directly connected with the administration of the program.
- _____ Unless notified in writing by a parent or legal guardian in objection to photographs and video footage taken of my child, these forms of multimedia may be used in CSPP/FCUSD-produced materials including but not limited to printed publications, and websites.
- _____ I understand that the California Department of Education, Department of Social Services, and Community Care Licensing has the authority to interview children or staff without prior consent. DSS and CCL have the authority to inspect, audit, and copy child or childcare center records upon demand during normal business hours. Records may be removed if necessary for copying. Removal of records shall be subject to the requirements in Sections 101217(c) and 101221 (d). DSS and CCL has the authority to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect of inappropriate placement.

Note: Authority cited Section 1596.81, Health, and Safety Code. Reference: Sections 1596.72, 1596.852, 1596.853, and 1596.8535, Health and Safety Code.

Parent/Guardian A Name (Printed): _____ **Date:** _____

Parent/Guardian A Signature: _____

Parent/Guardian B Name (Printed): _____ **Date:** _____

Parent/Guardian B Signature: _____

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Community Care Licensing Division

Licensing Office Address: 744 P Street, Sacramento, CA 95814

Licensing Office Telephone #: (916) 651-6040

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

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

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

PERSONAL RIGHTS**Child Care Centers**

See Title 22, Section 101223 of the California Code of Regulations for personal rights applicable to Child Care Centers.

- (a) Each child receiving services from a Child Care Center shall have rights which include the following:
- (1) To be accorded dignity in their personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet their 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 their authorized representative informed, by the licensee of the 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 their choice. Attendance at religious services, either in or outside the facility, shall be voluntary. In Child Care Centers, decisions concerning attendance at religious services shall be made by the child's authorized representative. To the extent that the child's authorized representative has agreed to the child's compulsory attendance at religious services and activities as a condition of admission in the admission agreement, a Child Care Center may require a child's attendance at such religious services and activities.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing Division

ADDRESS

744 P Street, Sacramento, CA 95814

CITY

Sacramento, CA

ZIP CODE

95814

AREA CODE/TELEPHONE NUMBER

(916) 651-6040

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

CONFIDENTIAL STUDENT HEALTH INFORMATION

STUDENT: _____

DATE OF BIRTH: _____

Physician's Name: _____

Phone: (____) _____

Name of Medical Insurance / Patient ID Number: _____

Does your child take any medication?* ☐ No ☐ Yes At School? ☐ No ☐ Yes

Please specify **name of medication** and **dosage:** _____

Prescribed by: Doctor's Name: _____

*See office staff for a *Medical Administration* form which is required for each medication to be administered at school.

<u>MEDICAL ALERT</u>	<u>ALLERGIES</u>
☐ No Known Health Problems	☐ Bee Sting _____ Local Reaction (Itching, Swelling) _____ Severe, Requires Emergency Treatment or Medication
☐ Asthma	☐ Medications Your Child is Allergic to: <i>(Please Specify)</i> _____
☐ Diabetes	☐ Foods Your Child is Allergic to: <i>(Please Specify)</i> _____
☐ Hearing Problems	☐ Other Allergies: _____
☐ Heart Condition	Describe Reaction: _____
☐ Seizure Disorder	
☐ Vision Problems _____ Glasses _____ Contact Lenses	
☐ Other Health Conditions: <i>(Please Specify)</i> _____ _____ _____ _____	

Dentist's Name: _____

Phone: (____) _____

For the health and safety of your child, the medical information you have shared above will be reviewed by the School Nurse and Site Administrator who will only release this information to those on staff with a legitimate need to know.

In case of an accident or sudden illness, when a parent or guardian is unavailable, I authorize a school representative to obtain medical care for my child, including necessary transportation, in accordance with their best judgment. I further authorize the doctor named above to provide the care and treatment he or she considers necessary. If the physician designated is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon selected by the school representative, who will be given the information on this card. I agree to pay all costs incurred as a result of the foregoing.

Folsom Cordova Unified School District, in cooperation with the California Departments of Health Services and Education, has a program to allow the District to be reimbursed with federal Medicaid dollars for selected health services provided to eligible students at school. In accordance with Local Education Agency rules and guidelines, we are notifying you that eligible student records may be forwarded, in a confidential manner, to the District's billing agency. Our vendor holds a contract with the District that contains a specific confidentiality clause to ensure information is not disclosed inappropriately; further, our vendor is HIPAA compliant (Federal Health Insurance Portability & Accountability Act).

Print Name of Parent/Legal Guardian

Parent/Guardian Signature

Date

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)**PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

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

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

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

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

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

(TODAY'S DATE)

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

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

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

RISK FACTORS FOR TB IN CHILDREN:

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

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

Parents' Guide to Immunizations

Required for Pre-Kindergarten (Child Care)



Parents must show their child's Immunization Record as proof of immunizations (shots) before starting pre-kindergarten (child care) and at each age checkpoint after entry:

Age at Entry/checkpoint	Required Doses
2–3 Months	1 Polio 1 DTaP 1 Hep B 1 Hib
4-5 Months	2 Polio 2 DTaP 2 Hep B 2 Hib
6-14 Months	2 Polio 3 DTaP 2 Hep B 2 Hib
15-17 Months	3 Polio 3 DTaP 2 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)
18 Months–5 Years	3 Polio 4 DTaP 3 Hep B 1 Hib* (on or after 1st birthday) 1 Varicella 1 MMR (on or after 1st birthday)

* One Hib dose must be given on or after the 1st birthday regardless of previous doses.
Required only for children younger than 5 years old.

DTaP = [diphtheria toxoid](#), [tetanus toxoid](#),
and acellular [pertussis](#) vaccine
 Hep B = [hepatitis B](#) vaccine
 Varicella = [chickenpox](#) vaccine

Hib = [Haemophilus influenzae, type B](#) vaccine
 MMR = [measles](#), [mumps](#), and [rubella](#) vaccine