CHILD CARE CENTER
NOTIFICATION OF PARENT’S RIGHTS

PARENT’S 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 person 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: Department of Social Services Childcare Licensing
Licensing Office Address: 2525 Natomas Park Drive, Suite 250
Licensing Office Telephone #: (916) 263-5744

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 BEHAVOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO THE CHILDREN IN CARE.

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

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

I, the parent/authorized representative of ________________________________, have received a copy of the “CHILD CARE CENTER NOTIFICATION OF PARENT’S RIGHTS”, and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

EGUSD, Prek-6 Education
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

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Staff Use Only: 2nd Year Parent Initial: ___________ Date: ___________

Revised 10/22/18
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 in his/her personal relationship 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, ridicule, coercion, threat, mental abuse, or other actions of a punitive natures, 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 provision 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 voluntary basis. In Child Care Centers, decision concerning attendance at religious services or visits from spiritual advisor shall be made by the parent(s) or guardian(s) of the child.

(6) Not to be locked in any room, building or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

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

NAME

Department of Social Services Childcare Licensing

ADDRESS

2525 Natomas Park Drive Suite #250

CITY

Sacramento

Zip Code

95833

Area Code/Telephone Number

(916) 263-5744

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

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

ACKNOWLEDGEMENT: 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:

Elk Grove Unified School District, PreK-6 Education

Elk Grove Unified School District, PreK-6 Education

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

Staff Use Only: 2nd Year Parent Initial: Date:

Revised 10/22/18
CONSENT FOR PHOTOGRAPHY FOR ASSESSMENT PURPOSES

I hereby consent for my child to be photographed and/or videotaped for use in the preschool classroom.

I understand the photographs/slides/video tapes of my child will be used to demonstrate best practice, instructional techniques and strategies in early childhood education settings. The visual materials created will be presented to Early Childhood educators, administrators and family representatives participating in the preschool programs.

I understand that no photograph, slide or video tape will be released to persons, agencies or publications without additional written permission.

☐ Yes, I agree to have my child photographed for assessment purposes.

☐ No, I do not agree to have my child photographed for assessment purposes.

INSPECTION AUTHORITY OF THE DEPARTMENT OF SOCIAL SERVICES

- Title 22, Division 12, Chapter 1, Article 4, Section 101200 (b) and (c)

I understand that:

(b) The Department has the authority to interview children or staff and to inspect and audit child or child care center records, without prior consent.

   (1) The license shall make provisions for private interview with any child(ren), or staff member; and for examination of all records relating to the operation of the child care center.

(c) The Department has the authority to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect or inappropriate placement.

Parent/Guardian’s Name (print): _______________________________

Parent/Guardian Signature: _______________________________ Date: _______________
# PRESCHOOL HEALTH AND DEVELOPMENT HISTORY

**Child's Name:** ____________________________  **Birthdate:** ____________________________  □ M  □ F

**Preschool Site:** ____________________________  □ AM  □ PM  □ FD  **Program Year:** □ 1  □ 2

**Medical Insurance:** □ Medi-Cal  □ None  □ Private Insurance: ____________________________  □ Foster

**Name of Child's Doctor:** ____________________________  **Phone:** ____________________________  **Medical Plan:** ____________________________

**Name of Child's Dentist:** ____________________________  **Phone:** ____________________________  **Dental Plan:** ____________________________

## HEALTH HISTORY

Does your child have any of the following:

- □ Yes  □ No  Asthma
- □ Yes  □ No  Diabetes
- □ Yes  □ No  Heart problems  If Yes, describe: __________________________________________________
- □ Yes  □ No  Seizures  If Yes, describe type: __________________________________________________
- □ Yes  □ No  Cerebral Palsy
- □ Yes  □ No  Severe bee sting/insect bite allergy
- □ Yes  □ No  Myringotomy (vent) tubes in ears
- □ Yes  □ No  Hearing Aids
- □ Yes  □ No  Vision Problems (child squints, eyes crossed, “lazy eye”, etc.)
- □ Yes  □ No  Eyeglasses prescribed by doctor  If Yes, does child wear eyeglasses? □ Yes  □ No
- □ Yes  □ No  Does your child use mobility equipment? (leg/ankle braces, walker, wheelchair): ____________________________
- □ Yes  □ No  Sickle Cell Disease / Sickle Cell Trait  (circle one)
- □ Yes  □ No  Other type of skin problem, describe: __________________________________________________
- □ Yes  □ No  Anemia (low iron in blood)
- □ Yes  □ No  Airborne allergies  If Yes, to what? __________________________________________________
- □ Yes  □ No  Is your child exposed to tobacco smoke?
- □ Yes  □ No  Any major illness or surgery?  Please describe: __________________________________________________
- □ Yes  □ No  Other medical needs or concerns?  Please describe: __________________________________________________
- □ Yes  □ No  Is your child seeing one of the following specialists:
  - □ Audiologist
  - □ ENT (ear, nose, throat doctor)
  - □ Neurologist
  - □ Optometrist (eye doctor)
  - □ Speech Therapist
  - □ Other: ____________________________

**Has your child ever received services from:**

- □ Alta Regional
- □ California Children Services (CSS)
- □ Mind Institute
- □ Shriner’s Hospital
- □ Special Education Services
- □ Other: ____________________________

## MEDICATION

- □ Yes  □ No  Does your child take any medications?
  If Yes, list: __________________________________________________

- □ Yes  □ No  Will your child need to take any medication at school?
  If Yes, list: __________________________________________________

## DENTAL HISTORY

- □ Yes  □ No  Has your child been seen by a dentist within the last 12 months?
  - Date last seen by dentist: ____________________________
  - Next dental appointment is on: ____________________________

- □ Yes  □ No  Does your child have any cavities?

- □ Yes  □ No  Does your child have any problems with painful teeth or gums?

- □ Yes  □ No  Does your child drink from a bottle?
**NUTRITION HISTORY**

- **Is your child allergic to any foods?** *(Please notify our preschool staff)*
  - Yes ☐  No ☐  If Yes, list: ________________________________

- **Has your child ever been prescribed an EpiPen or Antihistamine for food allergy?** *(Please notify our preschool staff)*
  - Yes ☐  No ☐

- **Is your child lactose intolerant?**
  - Yes ☐  No ☐

- **If your child on a special diet or tube feeding?** If Yes, describe: ________________________________
  - Yes ☐  No ☐

- **Is there any food your child should not eat for religious preference reasons?**
  - Yes ☐  No ☐  If Yes, list: ________________________________

- **Is your child vegetarian / vegan?**
  - Yes ☐  No ☐

- **Does your child eat any non-food items (such as clay, dirt, chalk) on a regular basis?**
  - Yes ☐  No ☐  If Yes, describe: ________________________________

- **Is child’s doctor aware of this condition?**
  - Yes ☐  No ☐

**How many times a day does your child have the following foods (includes school meals):**

<table>
<thead>
<tr>
<th>Food Type</th>
<th>1-2</th>
<th>3-5</th>
<th>&gt;6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cakes, cookies, candy, chips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soda, sweetened drinks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-meat: Beans, lentils, peanut butter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit: Apples, oranges, bananas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables: Broccoli, carrots, green beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grains: Cereal, bread, rice, grits, tortilla</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEVELOPMENT HISTORY:**

- **Walked by 14 months**
  - Yes ☐  No ☐

- **Used single words by 18 months**
  - Yes ☐  No ☐

- **Is toilet trained**
  - Yes ☐  No ☐

- **Developmental Concerns:** ________________________________
  - Yes ☐  No ☐

- **Behavioral Concerns:** ________________________________
  - Yes ☐  No ☐

**Child goes to bed by:** _______ PM  Wakes at: _______ AM  Naps: _______ hours per day

**PREGNANCY / BIRTH HISTORY**

- **Were there complications with the pregnancy or birth of this child?** If Yes, describe: ________________________________
  - Yes ☐  No ☐

- **Did mother use any medications, alcohol, street drugs or tobacco during pregnancy?** If Yes, describe: ________________________________
  - Yes ☐  No ☐

- **Did your child have any problems at birth or during first month of life?** If Yes, describe: ________________________________
  - Yes ☐  No ☐

- **Was your child born early (premature)?** If Yes, born at _______ gestation
  - Yes ☐  No ☐

**Please tell us anything else you would like us to know about child’s health:** ________________________________

**Parent/Guardian Name (Please print clearly):** ________________________________  ☐ Parent  ☐ Guardian  ☐ Foster Parent

**Parent/Guardian Signature:** ________________________________  **Date:** __________________

**Reviewed by Preschool Staff:** ________________________________  **Date:** __________________

**Staff Use Only:** 2nd Year Parent Initial: _______  **Date:** _______
HEALTH SERVICES CONSENT

Child’s Name: ___________________________________________  Birth Date: ______________________

We want your child to have the best chance for positive growth and development during his/her time with us in Head Start Preschool. Healthy children learn better. Head Start Preschool has health requirement and provides health screenings at school to help identify any medical or dental concerns that may require further education and/or treatment. We encourage you to be actively involved in your child’s health care.

At school, your child may be screened for vision, hearing, height/weight, dental, speech/language and development. These are required health screenings. The results of the screenings will be shared with you.

We want you to understand that the required medical, dental and other health screenings will help determine if your child needs a referral to a doctor, dentist, or another health specialist to address health concerns or learning needs. The information will also help us provide an education program suited to your child’s needs. All the information will be kept confidential.

Please check one box and sign below:

☐ Yes, I agree to have my child participate in any of the health screenings that are provided at school.

☐ No, I do not want my child to participate in any of the health screenings that are provided at school and will have them done by my child’s doctor.

_________________________________________  ________________  ___________________________________________  ________________
Parent/Guardian Signature                  Date                        Staff Signature                  Date

Staff Use Only:  2nd Year Parent Initial: ___________  Date: ___________
FACING THE FACTS:
A parent’s guide to the Understanding of CHILD ABUSE

Definition of Child Abuse
As used in the article, “child abuse” means a physical injury, which is inflicted by other than accidental means on a child by another person. “Child abuse” also means the sexual abuse of a child or any act or omission prescribed by Section 273a (willful cruelty or unjustifiable punishment of a child) or 273d (unlawful corporal punishment or injury). “Child abuse” also means the neglect of a child or abuse in out-of-home care, as defined in this article. “Child abuse” does not mean a mutual affray between minors.

Penal Code section 11165.6

Definition of Sexual Abuse
As used in this article “sexual abuse” means sexual assault or sexual exploitation as defined by the following: (a) “sexual assault” means conduct in violation of one or more of the following sections: section 261 (rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b) of section 288 (lewd or lascivious acts upon a child under 14 years of age), 288a (oral copulation), 289 (penetration of a genital or anal opening by a foreign object), or 647a (child molestation).

Penal Code section 11165.1

Definition of Neglect
As used in this article, “neglect” means the negligent treatment or the maltreatment of a child by a person responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child’s health or welfare. The term includes both acts and omissions on the part of the responsible person.

Penal Code section 11165.2

Contacts and services
For your information, the following chart shows what agencies may assist you in specific areas as listed below:

<table>
<thead>
<tr>
<th>* If you believe a child is being (or has been) abused by an individual (relative, friend)…</th>
<th>Police or Sheriff</th>
<th>County Dept. of Children’s Social Services</th>
<th>State or local Division of Community Care Licensing</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>* If you believe a child is has been assaulted by a stranger…</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* If you believe a child is being (or has been) abused in a licensed day care setting (child care center, school, recreational facility, family day care home)…</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* If you have any questions or complaints concerning the licensing organization, staffing or programs of a licensed child care setting…</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Mandated Reporters
While everyone should report suspected child abuse and neglect, the California Penal Code provides that certain professionals and laypersons must report suspected abuse to the proper authorities. The mandated reporters include:

* Any childcare custodian (teachers, licensed day care workers, foster parents, social workers)
* Medical Practitioners (physicians, dentists, psychologists, nurses)
* Nonmedical Practitioners (public health employees, counselors, religious practitioners who treat children)
* Employees of a child protective agency (sheriff, probation officers, county welfare department employees)

If abuse is suspected, a phone report to Police or CPS must be made immediately. Failure to submit the written report of suspected abuse by a mandated reporter (listed above) within 36 hours is a misdemeanor punishable by 6 months in jail and/or a $1,000 fine.

Remember, you have the primary responsibility for your child’s well being. With a little time, effort, and understanding you may prevent your child from being abused or assist your child when abuse has occurred.

CHILD ABUSE PREVENTION RECEIPT
This will acknowledge that I/We; the parent(s) of __________________________ have received a copy of “FACING THE FACTS: A PARENT’S GUIDE TO UNDERSTANDING CHILD ABUSE” from the licensee or authorized representative of the Elk Grove Unified School District, PreK-6 Education.

(Name of Child)

(Name of Facility)

Signature of Parent(s)/Guardian(s): __________________________ Date: __________________________

Staff Use Only: 2nd Year Parent Initial: __________ Date: __________

Revised 10/22/18
LEAD RISK ASSESSMENT

Child’s name: _____________________________ Birth Date: _____________________________

Please answer “Yes” or “No” to the questions below. Your answers will help us find out your child’s risk for lead exposure.

1. Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipping paint or that has been recently remodeled?  □ Yes □ No

2. Does your child eat candies that were made in another country? (Such as Balorindo, Chaca Chaca, Pelon Pelo Rico, Lucas Acidito, Tama Roca, Limon 7, or other)  □ Yes □ No

3. Do you use imported, old or homemade dishes or container to serve, prepare or store food or drinks, such as bean pots, clay pots, lead-soldered pots or cans, ceramic ware?  □ Yes □ No

4. Does your family use items from foreign countries, such as crayons, cockroach chalk, dried fruit/herbs, teas, candies, dried grasshoppers or other items?  □ Yes □ No

5. Do you or anyone else who lives with or cares for your child use home remedies such as Greta, Azarcon, Pay-loo-ah, or cosmetics such as Kohl or Surma?  □ Yes □ No

6. Does your child have a parent, brother, sister, housemate or a playmate who is being followed for lead poisoning or has an elevated blood lead level?  □ Yes □ No

The questions inside this box indicate an immediate referral.

7. Does your child live with or visit someone who may use lead in his/her work or hobbies? (For example: painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair, auto painting demolition or stained glass work)  □ Yes □ No

8. Does your child eat dirt, clay or other non-food items, chew on windowsills or pick at chipped paint?  □ Yes □ No

Date resources provided: _____________________________

9. Has your child lived in the United States for less than one year?  □ Yes □ No

10. Does your child visit other countries frequently?  □ Yes □ No

11. Does your child live near an active lead smelter or battery recycling plant or other industry that could release lead into the environment?  □ Yes □ No

12. Does your child live or play next to a freeway, such as at a babysitter’s house?  □ Yes □ No

NOTE: 2 or more “Yes” answers indicate an immediate referral, as well as any questions in the box above.

Parent/Guardian Signature: _____________________________ Date: _____________________________

Staff Signature: _____________________________ Date: _____________________________

Staff Use Only: 2nd Year Parent Initial: _____________ Date: _____________

Revised 10/22/18
Elk Grove Unified School District
PreK-6 Education

TB Risk Assessment

Child’s Name: ___________________________ Birth Date: ___________________________

Parents, your answers will help us find out your child’s risk for TB exposure.

One “Yes” response to any of the questions below indicates an automatic referral to your child’s physician for possible TB testing.

1. Has your child come in close contact with a person infected with TB? ☐ Yes ☐ No
2. Is the child infected with or at risk of infection of HIV? ☐ Yes ☐ No
3. Is the child foreign born, a refugee or a migrant? ☐ Yes ☐ No
4. Has the child had contact with an incarcerated person or a person who has been incarcerated within the last 5 years? ☐ Yes ☐ No
5. Has the child been exposed to any of the following:
   Nursing homes, institutionalized adolescents or adults, users of illicit drugs, migrant farm workers and/or those who have recently visited outside the U.S.? ☐ Yes ☐ No
6. Does the child live in a community in which it has been established at high risk? ☐ Yes ☐ No
7. Has the child traveled outside of the U.S. since his/her last medical visit? ☐ Yes ☐ No

Parent/Guardian Signature: ___________________________ Date: ___________________________
Staff Signature: ___________________________ Date: ___________________________

* Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they are not get treatment. There are tests that can be used to help detect TB infection: a skin test or TB blood test. If you think you have been exposed to someone with TB disease, contact your health care provider or local health department to see if you should be tested for TB infection.

Staff Use Only: 2nd Year Parent Initial: ____________ Date: ____________

Revised 10/22/18
PARENTAL CONSENT FOR ASSESSMENTS

Progress monitoring is an important component of our preschool program. Observations, screenings and assessments are conducted throughout the year to provide teachers with information on student progress. Screenings/testing results will be utilized by teachers to design instructional strategies to enhance students' learning. Results are confidential and are used only by the Elk Grove Unified School District PreK-6 Education staff. The following screenings/assessments may be administered:

Screenings/Observations
- Fluharty Preschool Speech and Language Screenings
- School Readiness Screenings
- Preschool Language Scare -5 (PLS-5)
- Observations
- ASQ-3
- ASQ-SE

Assessment
- Desired Results Developmental Profiles 2015

______________________________
Child’s Name: 
☐ Yes, my child may participate in the above screenings and assessments.
☐ Yes, the results of my child’s assessments may be forwarded to his/her next year’s teacher.
☐ No, my child may not participate in the above screenings and assessments.

Parent/Guardian Signature: ___________________________ Date: ______________

Staff Use Only: 2nd Year Parent Initial: _______________ Date: ___
Receipt of Information

I hereby acknowledge that I have received information from the Elk Grove Unified School District regarding the Elk Grove Unified School District Pre-Kindergarten Programs including information on parents’ legal rights and the Tobacco Free Schools Board Policy 33513 (a).

Name of Student: ____________________________________________________________

Signature of Parent/Guardian: __________________________ Date: ____________

Name of Parent/Guardian (Print): __________________________ Date: ____________

Staff Use Only: 2nd Year Parent Initial: __________ Date: ____________
CHILD RELEASE FORM

Child’s Name: ____________________________ Site: ____________________________
Parent’s/Guardian’s Name: ____________________________
Phone: ____________________________ (Cell / Home) Other: ____________________________

In the event that I am unable to pick my child up from preschool, I, ____________________________, give my permission/consent for my child, ____________________________, to be released to the following adult(s) who are at least 18 years of age and are recognized by my child.

If I arrange for my child to be picked up by someone not listed below, I understand that I must notify the classroom teacher by phone or in writing. Further, I understand that any adult who picks up my child must provide a photo identification card. If these requirements are not followed, I understand that my child will not be released to an adult other than myself or another legal custodial parent/guardian.

Parent/Guardian Signature: ____________________________ Date: ____________________________

PARENT/GUARDIAN: Please provide a minimum of two adults (other than child’s parents) who have permission to pick up your child from the classroom.

<table>
<thead>
<tr>
<th>ADULT’S NAME</th>
<th>PHONE NUMBER (WITH AREA CODE)</th>
<th>RELATIONSHIP TO CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<td>3.</td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2nd Year Parent Initial: ____________________________ Date: ____________________________

STAFF USE ONLY (To be completed at Parent Conferences)

1st Year Review/Update
1st Parent Conference
Parent/Guardian Date
2nd Parent Conference
Parent/Guardian Date

2nd Year Review/Update
1st Parent Conference
Parent/Guardian Date
2nd Parent Conference
Parent/Guardian Date

Revised 10/22/18
PHYSICAL/TUBERCULOSIS RISK ASSESSMENT/ DENTAL REQUIREMENT:

All children are required by Child Care Licensing (Title 22, 10122) to have completed a Physical Examination within 30 days of enrollment. TB Risk Assessment prior to entry/placement into the Pre-K program. Children who do not meet the 30-day Physical Exam requirement will be notified and temporarily exclude from attendance until requirements are received. An updated Dental Examination must be completed within the program year.

PRESCHOOL ADMISSIONS AGREEMENT BETWEEN ELK GROVE UNIFIED SCHOOL DISTRICT AND PARENTS/GUARDIANS OF PRESCHOOL CHILDREN

This agreement informs the parent/guardian of expectations for participating in preschool programs administered by PreK-6 Education. These expectations are applicable to Head Start, State and Title I Preschool.

1. ARRIVAL AND DEPARTURE POLICY:
   Arrival Time: Children are to always arrive in the classroom at the scheduled time.

   Signing-In and Out: For your child’s protection and in compliance with the State of California Child Care Licensing Law, you must sign your child in when you arrive and sign out when the child leaves.

   Departure Time: Children are to be picked up at the scheduled time. If your child is not picked up, the following procedures will be used:
   1) A verbal reminder will be given the first time the child is not picked up on time.
   2) A parent conference will be held the second time this occurs.
   3) A written reminder will be given the third time the child is not picked up on time.
   4) A parent conference will be held to discuss possible termination of your child from the program.

   Authorized Release of Children: Staff members will release children only to the parents or guardians (or a person explicitly authorized by the parent or guardian, age 18 or older).

2. PARENT PARTICIPATION:
   Parent participation is essential to your child’s successful school experience. You are highly encouraged to attend parent meetings and workshops and to volunteer in the classroom. Pursuant to Senate Bill 792, all adults spending time in a preschool classroom must be immunized against influenza, pertussis and measles. Volunteers may waive the influenza vaccination by signing a written declaration.

3. ABSENCE / ILLNESS:
   1) Children must attend class regularly. If your child is ill, you must notify the teacher.
   2) Parents will be contacted/ notified regarding unexcused absences or inconsistent attendance, which can result in your child being dropped from the class if attendance does not improve.
   3) Children who are absent ten (10) days or more without notification may be dropped from the class.

4. HOME VISITS / PARENT CONFERENCES:
   Parent conference are scheduled twice a year. For Head Start Preschool, teachers will also schedule two (2) or more home visits during the school year. Your participation is necessary to facilitate ongoing communication.

5. DISCIPLINE:
   Staff members are required to provide all children with a safe, healthy and comfortable learning environment. Expectations for all children will be clearly explained to children and to parent/guardians.

6. CONFIDENTIALITY:
   All information pertaining to children and families is maintained in a confidential manner. Release of information to an agency or other parties will not occur without written consent form the parent/guardian.

7. TRANSPORTATION:
   No transportation is provided to or from our preschool.

8. PLACEMENT:
   Upon completion of the student file, children will be placed based on criteria mandated by the grant funding the program.

PHYSICAL/TUBERCULOSIS RISK ASSESSMENT/ DENTAL REQUIREMENT:

All children are required by Child Care Licensing (Title 22, 10122) to have completed a Physical Examination within 30 days of enrollment. TB Risk Assessment prior to entry/placement into the Pre-K program. Children who do not meet the 30-day Physical Exam requirement will be notified and temporarily exclude from attendance until requirements are received. An updated Dental Examination must be completed within the program year.

PRESCHOOL ADMISSION AGREEMENT

I understand all of the above requirements.

Child’s Name: ___________________________  Program: ___________________________

Parent/Guardian Signature: ___________________________________  Date: __________

Staff Use Only:  2nd Year Parent Initial: ___________  Date: __________
Dear Health Care Provider:

Children who are enrolled in preschool in Elk Grove Unified School District (EGUSD) must meet the licensing requirements set forth by the California Department of Education.

These requirements include having a physical/dental exam performed by, or under the supervision of, licensed physical/dentist and must be completed within one year of enrollment into the program.

Licensing requirements state that the physical examination must include:

- Height
- Weight
- Blood Pressure
- Hematocrit or Hemoglobin (Blood count for anemia)
- Tuberculosis Risk Assessment or Tuberculosis Screen
- Vision Screen
- Hearing Screen
- Lead Screen (18 months)

To avoid the child possibly not being admitted into our program due to the physical examination not being complete, we are requesting that you screen for everything listed above.

A dental examination must be completed. If additional treatment is required, please provide the appointment dates.

Dear Parent/Guardian,

Please review the physical/dental exam forms to make sure all of the items have been completed before leaving the doctor’s office.
Dear Family Member of a Prospective PreK Student,

The Elk Grove Unified School District encourages parents and community members to volunteer in classrooms and at the school site beginning in PreK and continuing throughout your child’s education. In PreK we are dependent upon our volunteers. Without volunteers we cannot meet the demands of our grants and we cannot provide our children the focused attention and care they need. However, unlike Kindergarten through grade 12, PreK falls under State of California Community Care Licensing and Senate Bill 792 which require employees and volunteers having contact with children to be immunized against influenza, pertussis, and measles. Medical exemptions may be granted for those unable to be vaccinated due to health issues (verification from a doctor is required) and the influenza vaccination requirement can be waived by writing a written statement declining the vaccination.

Attached please find the verification form which must be filled out before a person may spend time in a preschool classroom. Unless the form is completed, your classroom time will be limited to signing your child in and out of class each day. We are hopeful that you already have these immunizations, and if so, that it will not be too difficult to find your verification of having received them. If you have not been vaccinated please work with the person who is helping to register your child. She will be able to give you information regarding where you can get vaccinated. When you have proof of immunization please give it to the person who is completing the registration packet for your child.

Thank you in advance for taking the time to complete this requirement which came into effect in September 2016.

EGUSD PreK

Elk Grove Unified School District – Excellence by Design

Revised 10/22/18
Child’s Name: ____________________________  Registering Site: ________________

To: Medical Provider  
Re: Senate Bill 792 – Required Influenza, Pertussis, and Measles Immunizations

Pursuant to Senate Bill 792, effective September 1, 2016, employees and volunteers within Elk Grove Unified School District’s (“District”) preschools must be immunized against influenza, pertussis, and measles. To verify that your patient, the “District” employee or volunteer, has met these requirements, please provide the information required under Option 1 or Option 2 below. If the patient is declining the influenza vaccine, the below Influenza Declaration must also be completed.

**OPTION 1**

Provide the patient with one of the following:

- An immunization card signed/dated by a licensed physician indicating the date the patient received each required immunization and when it will expire.
- Formal medical verification that is signed and dated by a licensed physician that waives immunizations due to health issues.
- Formal medical verification that is signed and dated by a licensed physician that certifies that the patient has evidence of current immunity to influenza, pertussis, and/or measles.

**OPTION 2**

To be completed by medical provider:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Type</th>
<th>Date Given</th>
<th>Administered By (Clinic, Doctor, Etc.)</th>
<th>Next Dose Due</th>
<th>Exempt Due to Health Issues? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (w/in 10 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

* Medical exemptions will be granted to those unable to be vaccinated due to Health issues.

Revised 10/22/18
INFLUENZA DECLARATION

Declaration by employer/volunteer:

I understand the information about the risks and benefits of the influenza vaccine. However, I decline the influenza vaccine at this time.

_________________________________________  ___________________________
Parent/Guardian’s Name                       Signature                      Date

_________________________________________  ___________________________
Student’s Name                                Relationship to student

DECLARACION DE INFLUENZA

Declaración por empleador / voluntario:

Entiendo la información sobre los riesgos y beneficios de la vacuna contra la influenza. Sin embargo, rechazo la vacuna contra la influenza en este momento.

_________________________________________  ___________________________
Nombre del Padre/Guardián                      Firma                          Fecha

_________________________________________  ___________________________
Nombre del Estudiante                          Relación con el Estudiante

Staff Use Only:  2nd Year Parent Initial:        Date:  

PRESCHOOL DENTAL HEALTH / EXAM RECORD

Child’s Name: ____________________________ Birthdate: ___________ □ M □ F

Parent/Guardian’s Name: ____________________________ Phone: ___________

Parent/Guardian Authorizations: I hereby give my consent to EGUSD PreK-6 Education and my physician to exchange health information concerning my child.
Parent/Guardian Signature: ____________________________ Date: ____________

DENTAL PROVIDER:

PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Tooth # or Letter</th>
<th>Description of Services Provided</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

In the diagram to the left, indicate oral conditions before treatment:

CHILD ORAL HEALTH SUMMARY (check one or more)

Date of Cleaning and Fluoride treatment: ________________

☐ No Treatment Needed ☐ Dental Treatment Received ☐ Preventative Care Given

☐ Needs Treatment:
  ☐ Specialist Referral given: ________________
  ☐ Approx. # of visits needed: ________________ Next Appointment Date: ________________

Comments: ____________________________________________

Dentist Name (Print): ____________________________ Signature: ____________________________ Date: ____________
Address: ______________________________________________________________________ Phone: __________________ Fax: ________________

* IF TREATMENT IS NOT COMPLETE, PLEASE FILL OUT A NEW FORM FOR EACH ADDITIONAL VISIT UNTIL TREATMENT IS COMPLETE.
Elk Grove Unified School District
PreK – 6 Education

AUTHORIZATION FOR RELEASE OF MEDICAL / DENTAL INFORMATION

Child’s Name: ________________________________ Date of Birth: ____________________ □ M □ F

I authorize the health medical/dental provider listed on this form to exchange medical/dental information with the Elk Grove Unified School District, PreK – 6 Education. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature: ________________________________ Date: ____________________

Practice/Clinic Name: ________________________________
Address: ________________________________
Phone: ________________________________ Fax: ________________________________

PHYSICAL/ TUBERCULOSIS RISK ASSESSMENT/ DENTAL REQUIREMENT:

All children are required by Child Care Licensing (Title 22, 10122) to have completed a Physical Examination within 30 days of enrollment. TB Risk Assessment prior to entry/placement into the Pre-K program. Children who do not meet the 30-day Physical Exam requirement will be notified and temporarily excluded from attendance until requirements are received. An updated Dental Examination must be completed within the program year.
Elk Grove Unified School District  
PreK-6 Education  
PRESCHOOL PHYSICAL EXAMINATION

Child’s Name: ___________________________  Birthdate: ________________  □ M  □ F

Parent/Guardian Name: ___________________________  Phone: ___________________________

Parent/Guardian Authorizations: I hereby give my consent to EGUSD PreK-6 Education and my physician to exchange health information concerning my child.

Parent/Guardian Signature: ___________________________  Date: ______________

REQUiRED (Note: Incomplete or blanks in this section will be returned to physician to complete)

<table>
<thead>
<tr>
<th>Date</th>
<th>Hemoglobin/Hematocrit: ___________</th>
<th>Receiving Treatment/Iron? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Blood Lead: ___________ ug/dL</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>TB Risk Assessment Given by Provider: □ Yes □ No → Child has TB Risk? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If “Yes”, PPD Date Given: ___________</td>
<td>Date Read: ___________</td>
<td>Results: □ Negative □ Positive</td>
</tr>
<tr>
<td>Rx Date: ___________</td>
<td>Chest X-Rays Date: ___________</td>
<td>Results: □ Negative □ Positive</td>
</tr>
</tbody>
</table>

REQUiRED (Starting at Age 3)

<table>
<thead>
<tr>
<th>Date</th>
<th>Blood Pressure: ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Vision: R: ___________ □ Pass □ Fail L: ___________ □ Pass □ Fail</td>
</tr>
<tr>
<td>Date</td>
<td>Hearing: (25db @1000, 2000 &amp; 4000) R: ___________ □ Pass □ Fail L: ___________ □ Pass □ Fail</td>
</tr>
</tbody>
</table>

Date of Physical Exam: ___________________________  HEIGHT: _______ IN.  WEIGHT: _______ LBS.

EXAMINATION RESULTS  NORMAL  ABNORMAL  DESCRIBE FINDINGS / COMMENTS

GENERAL APPEARANCE

HEAD, EARS, EYES, NOSE & THROAT

HEART / LUNG

ABDOMEN / GENITOURINARY

EXTREMITIES / SKELETAL

POSTURE AND GAIT

NEUROLOGICAL (Fine, Gross Motor)

SPEECH

SKIN

DEVELOPMENTAL STATUS

Health Concerns / Diagnosis:

Food Allergy: □ No □ Yes, List:

Lactose Intolerance: □ No □ Yes □ Other:

Medications Taken at Home: □ No □ Yes, List:

Medications Required at School: □ No □ Yes, List:

Physical Activity: □ No Restrictions □ Limited, Explain:

Special Education Services:

□ Speech Impairment  □ Developmental Delay  □ Learning Disability  □ Orthopedic Disability  □ Emotionally Disturbed

Active IEP: □ No □ Yes

Dental Referral: □ No □ Yes  Dental Varnish Given: □ No □ Yes  NaFl Given: □ No □ Yes

Nutrition Counseling Given: □ No □ Yes  Nutrition Counseling Referral: □ No □ Yes

Immunizations Given: □ Polio □ DTP/DTaP □ MMR □ Hep B □ Hib □ Varicella

Physician’s Name: ___________________________  Signature: ___________________________  Date: ______________

Address: ___________________________  Phone: ___________________________  Fax: ___________________________

PRESCHOOL OFFICE USE ONLY  Date received by PreK office  Date Received by classroom  Date entered into Child Plus  Date Event closed in Child Plus

Revised 10/22/18
STUDENT INFORMATION

Has student ever attended an EGUSD School (including Preschool): ☐ YES ☐ NO

EGUSD Student ID# _____________________________

Is this student currently expelled or pending an expulsion hearing in EGUSD or any other District? ☐ YES ☐ NO

*Indicates that a response is required

**Student’s full legal name**
(As it appears on birth certificate)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Suffix (Jr. II. IV)</th>
</tr>
</thead>
</table>

Grade Level _______________  Student’s SSID# (if known) _______________  *Gender: ☐ Male ☐ Female

Nick Name  AKA Last Name  AKA First Name  AKA Middle Name  AKA Suffix

*Birth Date (Month/Day/Year): _______________  *Birthplace:

City  State  Country

Student’s Email Address:

RACE / ETHNICITY

*1) Ethnicity  ☐ Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South/Central American or other Spanish culture or origin)  ☐ Not Hispanic or Latino

*2) Race – Please select one or more Race Categories

☐ White  ☐ African American-Black  ☐ American Indian

☐ Chinese  ☐ Japanese  ☐ Korean

☐ Vietnamese  ☐ Asian Indian  ☐ Laotian

☐ Cambodian  ☐ Hmong  ☐ Other Asian

☐ Native Hawaiian  ☐ Guamanian  ☐ Samoan

☐ Tahitian  ☐ Other Pacific Islander  ☐ Filipino

DEMOGRAPHICS

*Residence Address:

(Number & Street – Apt.) (City) (State) (Zip Code)

*Mailing Address:

(If different from Residence address)  (Number & Street – Apt. or P.O.) (City) (State) (Zip Code)

*Primary Phone: _______________  *Type: ☐ Home ☐ Personal Cell ☐ Work

HOME LANGUAGE SURVEY  (For “new” student registrations only, i.e. students registering for enrollment in the District for the first time.)

*1. Which language did your child learn when he/she first began to talk? ____________________________

*2. What language does your child most frequently speak at home? ____________________________

*3. What language do you most frequently use at home when speaking with your child? ____________________________

*4. What is the language most often spoken by the adults in the home? ____________________________

(parenths, guardians, grandchildren, or any other adults)

FOR OFFICE USE ONLY

School Name_____________  Enrollment Date_____________  Birth Date Verified ☐  Birthplace Verified ☐

Birth Verification Method  Address Verification Method (1) (2)

Immunizations Complete? ☐ YES ☐ NO  Student Notifications? ☐ YES ☐ NO  Permit Type_____________  Permit Date_____________

Track_________  Enrolled by_____________  Date entered in Synergy_____________
ADDITIONAL STUDENT INFORMATION

Which of the following best describes where this child is currently living, if applicable? (Federally Required)
Homeless (If yes, please identify residence category) ☐ Temporary shelter ☐ Hotel/Motel ☐ Temporarily doubled-up ☐ Temporarily unsheltered
Foster Primary Residence (If yes, please identify dwelling type) ☐ Foster Family Home or Kinship Plan ☐ Licensed Children’s Institution (Group Home)

What special services has your child received?
□ 504 Accommodation  ☐ GATE  □ Special Ed. Program  □ ESL/Bilingual  □ None
□ Request for Migrant Ed.  Migrant Student ID: ____________________________________________

PARENT/GUARDIAN INFORMATION

*Parent/Guardian: ___________________________________________  *☐ Legal Guardian  *☐ Other
*Relationship: ______________________________ Does this person live with student: ☐ YES ☐ NO
Release contact: ☐ YES ☐ NO
*Mailing Address: ______________________________ (Number & Street) (City) (State) (Zip Code)
*Primary phone: Contact? Not Listed?
☐ Home Telephone: ☐ ☐
☐ Personal Cell: ☐ ☐
☐ Work Phone: Ext. # ☐ ☐
*Email Address: ____________________________________________ Preferred Language: ________________________

*Education level - please check one box that most closely applies:
☐ Not a high school graduate  ☐ Some college or Associate's degree  ☐ Graduate school/post graduate
☐ Graduated from high school  ☐ College graduate

Military Service: ☐ Active in Armed Forces  ☐ Full-time National Guard  ☐ Armed Forces Reserve

Parent/Guardian: ___________________________________________  *☐ Legal Guardian  *☐ Other  Deceased: ☐ YES
*Relationship: ______________________________ Does this person live with student: ☐ YES ☐ NO
Release contact: ☐ YES ☐ NO
*Mailing Address: ______________________________ (Number & Street) (City) (State) (Zip Code)
Primary phone: Contact? Not Listed?
☐ Home Telephone: ☐ ☐
☐ Personal Cell: Ext. # ☐ ☐
☐ Work Phone: Ext. # ☐ ☐
Email Address: ____________________________________________ Preferred Language: ________________________

*Education level - please check one box that most closely applies:
☐ Not a high school graduate  ☐ Some college or Associate's degree  ☐ Graduate school/post graduate
☐ Graduated from high school  ☐ College graduate

Military Service: ☐ Active in Armed Forces  ☐ Full-time National Guard  ☐ Armed Forces Reserve

ENROLLMENT

Previous School Attended: _____________________________________________
(Name of School) (Address) (City) (State) (Zip) (Phone / Fax #)
Previous School District: _____________________________________________ Last Date Attended: __________________________

*What month, day and year did your child enter (or enroll) in a California Public School?  Month/Day/Year: __________________________

*U.S. School Entry Date: - Month/Day/Year: __________________________

Please complete ALL pages of this form
**ADDITIONAL STUDENT INFORMATION**

---

**NAMES OF ALL/OTHER CHILDREN IN FAMILY (ALL AGES)**

<table>
<thead>
<tr>
<th>NAMES OF ALL/OTHER CHILDREN IN FAMILY (ALL AGES)</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH</th>
<th>SCHOOL OF ATTENDANCE</th>
<th>LIVING AT HOME</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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</table>

**Emergency Contacts:**

Individuals who may be contacted in an emergency when no Parent or Guardian can be reached.

*(Valid identification must be provided in order to release student.)*

**Relationship:**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Name</th>
<th>Release</th>
<th>Home Telephone</th>
<th>Personal Cell</th>
<th>Work Phone</th>
<th>Ext.</th>
<th>Email Address</th>
<th>Preferred Language</th>
<th>Release</th>
<th>YES</th>
<th>NO</th>
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**Day Care Provider Name:**

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<thead>
<tr>
<th>Day Care Provider Name</th>
<th>Cell Phone</th>
<th>Home Phone</th>
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<tr>
<th>Address</th>
<th>City</th>
<th>Zip Code</th>
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<table>
<thead>
<tr>
<th>Probation Officer</th>
<th>Email Address</th>
<th>Phone/Ext.</th>
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<thead>
<tr>
<th>Social Worker (Agency)</th>
<th>Email Address</th>
<th>Phone/Ext.</th>
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<tr>
<th>Social Worker (County)</th>
<th>Email Address</th>
<th>Phone/Ext.</th>
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<thead>
<tr>
<th>Physician Name</th>
<th>Phone</th>
<th>Ext.</th>
<th>Hospital</th>
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<tr>
<th>Insurance Company</th>
<th>Phone</th>
<th>Ext.</th>
<th>Policy #</th>
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**Additional Information:**

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**HEALTH RECORD**

☐ PLEASE CHECK HERE IF STUDENT HAS NO KNOWN HEALTH PROBLEMS

Please check any and all conditions in this student’s medical history. Use the area below to add an explanation/recommendation.

☐ MEDICAL ALERT (unlisted condition – describe below)

☐ ADHD ☐ Asthma ☐ Concussion ☐ Headache - Migraine ☐ Immunization Alert ☐ Specialized Healthcare Procedure

☐ Allergy – Nonfood ☐ Autism ☐ Cystic Fibrosis ☐ Health Plan ☐ Intestinal Disorder ☐ Speech Impairment

☐ Allergy – Food ☐ Autoimmune Disorder ☐ Dental ☐ Hearing Impairment ☐ Orthopedic / Scoliosis ☐ Syndrome – Other

☐ Allergy - Nut ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Pacemaker ☐ Tuberculosis

☐ Allergy - Peanut ☐ Cancer ☐ Eating Disorder ☐ Hepatitis ☐ Seizure Disorder ☐ Urinary Disorder

☐ Anxiety Disorder ☐ Celiac Disease ☐ Eczema ☐ Hypertension ☐ Sickle Cell Anemia ☐ Vision Impairment

☐ Arthritis ☐ Cerebral Palsy ☐ Fracture ☐ IEP Nursing Services ☐ Skin Condition – Other ☐ Weight Disorder

**Explanation/Recommendations regarding above:**

---

Is the student currently taking medications? ☐ YES ☐ NO ☐ Yes ☐ NO

**MEDICATION CANNOT BE DISPENSED AT SCHOOL WITHOUT A FORMAL REQUEST SIGNED BY A DOCTOR AND PARENT.**

**MEDICATION FORMS ARE AVAILABLE IN THE SCHOOL OFFICE.**

I UNDERSTAND THAT IN AN EMERGENCY WHEN NO GUARDIAN OR EMERGENCY CONTACT CAN BE LOCATED, THE SCHOOL IS AUTHORIZED TO TAKE MY STUDENT TO THE FAMILY DOCTOR, LICENSED PHYSICIAN OR TO THE NEAREST HOSPITAL AT PARENT/GUARDIAN EXPENSE.

---

**Name of person completing form (please print):** ____________________________  **Relationship:** ____________________

**Signature of Parent/Guardian (certifying information provided is accurate):** ____________________  **Date:** ____________________

Please complete ALL sections of this form  Page 3 of 3

Thank You!