Elk Grove Unified School District

Elk Grove Unified School District
PreK-6 Education

Priority is given to 4 year olds.

Children with disabilities are encouraged to apply

Looking for Preschool for your child?

REGISTER NOW FOR THE 2022-2023 PROGRAM YEAR

You may qualify for a free Preschool program if:

- Your child is 3 or 4 years old
- You meet the income guidelines for **Head Start** or **State Preschool**
- You live in the attendance area of a **Title I School**

Registration packet can be completed electronically and submitted via email

Step 1: Fill out this registration packet.
Step 2: Collect all required documents listed below.

IF PACKET SUBMITTED: VIA EMAIL

1. Email to prekreg@egusd.net
2. Include Scan/Photos of required documents

IF PACKET SUBMITTED: VIA DROP OFF

1. Drop off to designated Office Assistant
2. Drop off ***copies*** of required documents OR email photos of required documents

Required Documents (in addition to registration packet):

- ☐ Birth certificate for registering child (*Certified or hospital*)
- ☐ Birth certificate for ***ALL*** siblings in the home under 18 years of age: to verify family size *(Certified or hospital)*
- ☐ Most current and consecutive 30 days of any/all income: *(Check stubs, Tax Return, disability, SSI, TANF, or CalWORKs.)*
- ☐ Immunization records or document from physician
- ☐ Current address verification: *(Property tax receipt, mortgage statement, rental/lease agreement, utility/rental receipt, recent parent/guardian pay stub, voter registration or government agency documentation, ID/CDL.)*
- ☐ Name of Dental and Medical Plan
- ☐ Medical, Dental, and/or Medi-Cal Insurance Cards
- ☐ WIC #, *if applicable*
- ☐ Parent/Guardian immunizations *(Pertussis, Measles and Influenza)* are required to volunteer.

In addition, *if applicable*:

- ☐ Court documentation for guardianship/foster care/custody/restraining orders
- ☐ Individualized Education Plan (IEP) if your child is receiving Special Education services (speech therapy, etc.)

Elk Grove Unified School District

ELK GROVE UNIFIED SCHOOL DISTRICT (EGUSD)

Part I: Student Enrollment Form

Today's Date

____/____/____

Information on this page is required for enrollment.

STUDENT INFORMATION

Has student ever attended an EGUSD School (including Preschool): ☐No ☐Yes **EGUSD Student ID #**_____

Is this student currently expelled or pending an expulsion hearing in EGUSD or any other district? ☐Yes ☐No

Student's Full Legal Name _____

Last First Middle Suffix (Jr. III, IV)

Grade Level _____ Gender: ☐Male ☐Female ☐Non-Binary Nickname _____

AKA/Other Name: Last Name _____ First Name _____ Middle Name_____Suffix___

Birth Date (Month/Day/Year) _____ Student's Email _____Student's Cell _____

RACE/ETHNICITY

Ethnicity: ☐Not Hispanic ☐Hispanic/Latinx (person of Cuban, Mexican/ Puerto Rican, South/Central American or other Spanish culture or origin)

Race – Please select all that apply

☐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	☐Filipinx

DEMOGRAPHICS

Residence Address_____

Number & Street – Apt City State Zip Code

Mailing Address _____

(if different from residence address) P.O. Box / Number & Street City State Zip Code

HOME LANGUAGE SURVEY

1. Which language did your child learn when they 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? _____
   (e.g., parents, guardian, grandparents, or any other adults)

FOR OFFICE USE ONLY

School Name_____ Enrollment Date_____ Birth Date Verified ☐

Birth Date Verification Method_____ Address Verification Method(s) _____

Immunizations Complete? ☐ YES ☐ NO Student Notifications? ☐ YES ☐ NO Permit Type_____ Permit Date_____

Track _____ Enrolled by_____ Date entered in Synergy_____

Updated: 06/2019

Information on this page is required for enrollment.

PARENT/GUARDIAN INFORMATION

Parent/Guardian_____ ☐Legal Guardian ☐Other

Relationship _____ Does this person live with student? ☐Yes ☐No Release contact ☐Yes ☐No

Mailing Address _____
(if different from student) Number & Street – Apt City State Zip Code

Cell _____Work_____Home_____

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 Armed Forces ☐Full-Time National Guard ☐Armed Forces Reserve

PARENT/GUARDIAN INFORMATION

Parent/Guardian_____ ☐Legal Guardian ☐Other ☐Deceased

Relationship _____ Does this person live with student? ☐Yes ☐No Release contact ☐Yes ☐No

Mailing Address _____
(if different from student) Number & Street – Apt City State Zip Code

Cell _____Work_____Home_____

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 Armed Forces ☐Full-Time National Guard ☐Armed Forces Reserve

Name of person completing form **(please print)**: _____Relationship: _____

Signature of Parent/Guardian: _____Date: _____
(certifying information provided is accurate)

Thank you for completing the student enrollment process.
Your information will be reviewed to register your child in the Elk Grove Unified School District.

Part II: Supplemental Student Information Form

Now that you have completed the required enrollment information, please provide us with additional information to support your student's placement and services.

Student Name: _____
Parent/Guardian: _____

EDUCATIONAL PROGRAM PARTICIPATION ELIGIBILITY

What special services has your child received?

☐None ☐504 Accommodation ☐GATE ☐Special Education ☐English Language Development (ELD) ☐Bilingual

☐Request for Migrant Education Migrant Student ID: _____

Do you have refugee status? ☐Yes ☐No Are you a holder of a Special Immigrant Visa? ☐Yes ☐No

Which of the following best describes where this child is currently living, if applicable? (Federally Required)

- Homeless (If yes, please identify residence category): ☐Yes ☐No
  ☐Temporary Shelter ☐Hotel/Motel ☐Temporarily Doubled-up ☐Temporarily Unsheltered

- Foster Primary Residence (if yes, please identify dwelling type): ☐Yes ☐No
  ☐Foster Family or Kinship ☐Licensed Child Institution (Group Home)

PRESCHOOL ATTENDANCE

Did your child attend preschool? ☐Yes ☐No
If yes, what type of preschool? ☐EGUSD Preschool ☐Other Public ☐Private

ADDITIONAL DEMOGRAPHIC INFORMATION

Birthplace: City _____ State _____ Country _____

U.S. School Entry Date: ____/____/_____ City _____ State _____

NAMES OF ALL OTHER CHILDREN IN FAMILY (ALL AGES)

NAME	RELATIONSHIP	DATE OF BIRTH	SCHOOL OF ATTENDANCE	LIVING AT HOME
				☐
				☐
				☐
				☐
				☐

PREVIOUS ENROLLMENT

Previous School Attended _____Last Date Attended_____

_____

Address City State Zip Phone Fax

Name of Previous School District_____

EMERGENCY CONTACTS: Individuals who may be contacted in an emergency when no parent or guardian can be reached.

Relationship _____ Name_____ Release Contact ☐Yes ☐No

Home Phone _____Work_____Cell_____

Relationship _____ Name_____ Release Contact ☐Yes ☐No

Home Phone _____Work_____Cell_____

Relationship _____ Name_____ Release Contact ☐Yes ☐No

Home Phone _____Work_____Cell_____

Daycare Provider_____

Name Address City Zip

Home Phone _____ Work_____ Cell_____ Release Contact ☐Yes ☐No

ADDITIONAL CONTACTS

Physician Name _____ Phone _____Ext _____Hospital _____

Insurance Provider _____MED Policy # _____

Social Worker (Agency) _____Email _____Phone_____

Social Worker (County) _____Email _____Phone_____

Probation Officer _____Email _____Phone_____

HEALTH RECORD ☐PLEASE CHECK HERE IF STUDENT HAS NO KNOWN HEALTH PROBLEMS

Please check any and all conditions in this student's 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 – Non-food	☐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	☐EP Nursing Services	☐Skin Condition – Other	☐Weight Disorder

Explanation/Recommendations regarding above: _____

_____

Is the student currently taking medications? ☐Yes ☐No Is the medication required during school hours? ☐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: _____Date: _____

(certifying information provided is accurate)

Please complete both pages

Updated: 06/2019

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 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 Child Care 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 BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK OT THE CHILDREN IN CARE.***

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

LIC 995 (9/08)

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.

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

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

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 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 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 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, decisions concerning attendance at religious services or visits from spiritual advisors 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 Child Care Licensing		
ADDRESS		
2525 Natomas Park Drive Suite #250		
CITY	Zip Code	ARE CODE/TELEPHONE NUMBER
Sacramento	95833	(916) 263-5744

TO: PARENT/GUARDIAN/CHIILD 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:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Elk Grove Unified School District, PreK-6 Education	9510 Elk Grove-Florin Rd. Room 211 Elk Grove 95624

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN	(DATE)

LIC 613 (8/08)

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

Elk Grove Unified School District
PreK-6 Education

Child's Name: _____ Birth Date: _____

_____ **CONSENT FOR PHOTOGRAPHY FOR ASSESSMENT PURPOSES**

Initials

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**

Initials **- 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 Name (print): _____

Parent/Guardian Signature: _____ Date: _____

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

Elk Grove Unified School District
PreK-6 Education

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 requirements 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 educational program suited to your child's needs. All the information will be kept confidential.

Please check one box and sign below:

I am aware of the health services and screenings required for the Head Start Preschool Program.

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

_____ _____

Parent/Guardian Signature Date Staff Signature Date

☐ **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:

	Police or Sheriff	County Dept. of Children's Social Services	State or local Division of Community Care Licensing
* If you believe a child is being (or has been) abused by an individual (relative, friend)…	X	X	
* If you believe a child is has been assaulted by a stranger…	X		
* 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) …	X		X
* If you have any questions or complaints concerning the licensing organization, staffing or programs of a licensed child care setting…			X

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, the parent of _____ have received a copy of
(Name of Child)

"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 Facility)

Signature of Parent/Guardian: _____ Date: _____

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

Reviewed12/22/2021

Elk Grove Unified School District
PreK-6 Education

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-IF YES, complete Asthma Checklist
☐ 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 Eczema ☐ 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/second hand 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: _____

☐ Yes ☐ No **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 *<u>at school</u>*?**
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 or sippy cup?

NUTRITION HISTORY

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

☐ Yes ☐ No **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?
If Yes, list: _____

☐ Yes ☐ No Is your child vegetarian / vegan?

☐ Yes ☐ No Does your child eat any non-food items (such as clay, dirt, chalk) on a regular basis?
If Yes, describe: _____
Is child's doctor aware of this condition? ☐ Yes ☐ No

☐ Yes ☐ No Does your child receive WIC? WIC Number: _____

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

	1-2	3-5	>6
Cakes, cookies, candy, chips, ice cream	☐	☐	☐
Soda, sweetened drinks, fruit drinks	☐	☐	☐
Non-meat: Beans, lentils, nut butters, hummus, tofu	☐	☐	☐
Fruit: Apples, oranges, bananas, grapes, berries, melon	☐	☐	☐
Vegetables: Broccoli, carrots, green beans, squash, corn	☐	☐	☐
Grains: Cereal, bread, rice, grits, tortilla, naan, oats, granola	☐	☐	☐
Dairy: Milk, yogurt, cheese, eggs, milk alternatives	☐	☐	☐

DEVELOPMENT HISTORY:

☐ Yes ☐ No 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: _____

Child goes to bed by: _____PM Wakes at: _____AM Naps: _____ hours per day

PREGNANCY / BIRTH HISTORY

☐ Yes ☐ No 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

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: _____

Elk Grove Unified School District
PreK-6 Education

LEAD RISK ASSESSMENT

Child's name: _____ Birth Date: _____

Please answer "Yes" or "No" to the questions below. Your answers will help us determine 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 Pulparindo, Chaca Chaca, Pelon Pelo Rico, Lucas Acidito, Tama Roca, Limon 7, or others) ☐ Yes ☐ No
3. Do you use imported, old or homemade dishes or containers 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:
November Parent Conference (HS Only): Parent Initial: _____ Date: _____
2nd Year Parent Initial: _____ Date: _____

Reviewed 12/22/2021

Elk Grove Unified School District
PreK-6 Education

TB Risk Assessment

Child's Name: _____ Birth Date: _____

Please answer "Yes" or "No" to the questions below. Your answers will help us determine 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 be fatal if treatment is not received. 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, contact your health care provider or local health department to see if you should be tested for TB infection.*

Staff Use Only:
November Parent Conference (HS Only): Parent Initial: _____ Date: _____
2nd Year Parent Initial: _____ Date: _____

Reviewed 12/22/2021

Elk Grove Unified School District
PreK-6 Education

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
- Observations
- ASQ-3
- ASQ-SE

Assessment

- Desired Results Developmental Profiles 2015 (IDP)

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: ____

Reviewed 12/22/2021

Elk Grove Unified School District
PreK-6 Education

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: _____

Elk Grove Unified School District
PreK-6 Education

CHILD RELEASE FORM

Child's Name: _____ Site: _____

Parent/Guardian 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.

ADULT'S NAME	PHONE NUMBER (WITH AREA CODE)	RELATIONSHIP TO CHILD
1.		
2.		
3.		
4.		
5.		

Staff Use Only: 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

Elk Grove Unified School District
PreK-6 Education

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 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 your child arrives and sign your child out when your child leaves.

Departure Time: Children are to be picked up at the scheduled time. If your child is not picked up, the following process will be followed:

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 the child is not picked up on time.
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 the fourth time the child is not picked up on time to discuss possible termination 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 noted on Child Release Form).

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 wave the influenza vaccination by signing a written declaration. E.G.U.S.D. policy requires all parent volunteers to be fingerprinted-http://www.egusd.net/about/district/safety/

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 and placed on a wait list.

4. **HOME VISITS/PARENT CONFERENCES:**

Parent conferences 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 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 from the parent/guardian.

7. **INSTRUCTION:**

The program will not provide religious instruction or worship.

8. **CODE OF CONDUCT:**

Personnel, parents and guardians will conduct themselves in a civil and respectful manner in accordance with EGUSD's Human Dignity Policy.

9. **TRANSPORTATION:**

No transportation is provided to or from our preschool.

10. **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 22,101220) to have completed a physical examination and TB Risk Assessment within **30 days of enrollment**. 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.

I understand all of the above requirements.

Child's Name:

Parent/Guardian Signature: _____ Program: _____

_____ Date: _____

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

Reviewed 12/22/2021

Tabitha Thompson
Director, PreK-6 Education

(916) 686-7704
FAX: (916) 686-7796
Email: tethomps@egusd.net

Robert L. Trigg Education Center
9510 Elk Grove-Florin Rd., Elk Grove, CA 95624

Dear Health Care Provider: **(Please complete Health Forms provided by E.G.U.S.D.)**

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 physician/dentist and **must be completed within 30 days of entry 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 possibility of the child not being admitted into our program due to an incomplete physical, we request that you screen for all the requirements 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 the items have been completed **before** leaving the doctor's office. Completed physical and/or dental can be returned to designated preschool office or via email.

Elk Grove Unified School District
PreK-6 Education

PRESCHOOL PHYSICAL EXAMINATION

Child's Name:_____ **Birth Date:**___/___/___ **Gender: F M Non-Binary**

Parent/Guardian Name:_____ **Phone:** _____

Parent's/Guardian Authorization: I hereby give my consent to an Elk Grove Unified District representative 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)

Date:_____ Hemoglobin/Hematocrit:_____ At Risk for Anemia? Yes☐ No☐ Receiving TX? Y N
Date:_____ Blood Lead:_____ ug/dl At Risk for Lead Poisoning? Yes☐ No☐ Receiving F/U? Y N
Date:_____ TB Risk Assessment Given by Provider: Yes ☐ No ☐ Child has TB Risk? Y N
If Yes, PPD Date Given:_____Date Read:_____Results:_____

Required (Starting at Age 3)

Date:_____ Blood Pressure:_____
Date:_____ Hearing: (*25db @1000,2000,&4000*) **R:**☐ Pass ☐ Fail **L:**☐ Pass ☐ Fail
Date:_____ Vision: **R:** 20/____☐ Pass☐ Fail **L:** 20/____☐ Pass☐ Fail

Date of Physical Exam:	**HEIGHT:** **IN**	**WEIGHT:** **LBS**

Examination Results	Normal	Abnormal	Describe Findings / Comments
General Appearance			
Head, Ears, Eyes, Nose & Throat			
Teeth / Gums			
Heart / Lung			
Abdomen / Genitourinary			
Extremities / Skeletal			
Posture and Gait			
Neurological (Fine, Gross Motor)			
Speech			
Skin			
Developmental Status			

Visual Acuity Concerns? ☐ **No** ☐ **Yes, If yes, referred?** ☐ **Yes** ☐ **No Name of Specialist** _____
Hearing Acuity Concerns? ☐ **No** ☐ **Yes, If yes, referred?** ☐ **Yes** ☐ **No Name of Specialist** _____

Health Concerns / Diagnoses:

Food Allergy: ☐ **No** ☐ **Yes List** _____
Lactose Intolerance: ☐ **No** ☐ **Yes List** _____
Other Severe Allergy (e.g. Latex, bee sting, scents): List _____

Medications Taken at Home? ☐ **No** ☐ **Yes, List:** _____
Medications Required at School? ☐ **No** ☐ **Yes, List:** _____

Physical Activity: ☐ **No Restrictions** ☐ **Limited, Explain:**_____

Special Education Services? ☐ **No** ☐ **Yes** **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**

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 12/29/21

Elk Grove Unified School District
PreK-6 Education

PRESCHOOL DENTAL HEALTH / EXAM RECORD

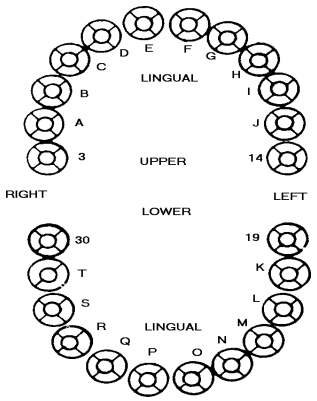
Child's Name:_____Birth Date: ___/___/___ **Gender: F M Non-Binary**

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:** _____

DENTAL PROVIDER:



PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY

Date of Service	Tooth # or Letter	Description of Services Provided

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

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.***

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