WELCOME TO PRESCHOOL

We are so excited to have your child start preschool with us at _____ preschool!

Please help us make this process smoother and faster by following the instructions bellow:

- Fill out all the forms and write clearly.

- Use first and last name.

- Be sure to sign and date where indicated.

- Do your best to complete all the forms. If you have any questions, please call us at (619) 425-9600 ext. 181510.

- **The VERIFICATION OF RESIDENCY form needs to be completed by the parent whose name appears on the document that was used as proof of residency.**

- Please read carefully the form called **SWORN STATEMENT** and complete only that which applies to your family. **If there is a non-working parent in the household, they need to complete part A and sign the form.**

- The **AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL INFORMATION** form needs to be completed and signed by the parent who is working. **If both parents are working, each one must complete the form.**

- The **PHYSICIAN'S REPORT** form. The top section needs to be completed by the parent, the bottom section by the child's pediatrician. This form needs to be given to the teacher on the first day of school. If not possible, you have 30 days after the first day of your child's attendance to turn it in.

- On the form called **CONFIDENTIAL APPLICATION FOR CHILD DEVELOPMENT SERVICES (9600)**, please only complete the highlighted sections.

- **THE DUE DATE FOR RETURNING THE PACKET IS ONE WEEK FROM THE DATE RECEIVED**

- Please return the documents by any of the following options:

  - Scan or photograph forms and email to: cvesd.preschoolpacket@cvesd.org
  - Drop packet with all the forms in the drop box located outside of our main office. The office is located behind the main building of the Chula Vista Elementary School District.
  - Mail completed packet to:
    Chula Vista Elementary School District
    Attention Preschool
    84 E J St. Chula Vista CA 91910

- When everything is completed and returned you will receive a Notice of Action with start date and school information. This final document will solidify your child's placement in preschool.

Thank you so much for the opportunity to support your child's education.

Chula Vista Elementary School District

VERIFICATION OF RESIDENCY

In accordance with Title 5, California Code of Regulations section 432(F)(2), California school districts must verify student residency annually.

In order to verify residency within the Chula Vista Elementary School District, one current document must show parent/guardian/caregiver name and address and must be dated within 60 days prior to your child's first day of school. Past due bills are not acceptable for verification. Post Office box numbers are not acceptable as residence addresses.

Address: _____

_____Mortgage book statement
_____Homeowner's association billing statement
_____New rental contract/lease, and current payment receipt w/landlord contact inf.
_____Letter on apartment complex or mobile home park letterhead, signed by the landlord,
_____Stating that parent/guardian/caregiver/ lives there
_____Gas & Elec ___Water ___ Sewer ___ Trash ___ Cable ___ Landline Phone ___ Internet
_____Pay stub _____ Voter registration _____ Property Tax payment receipt
_____Correspondence from a government agency

I, _____ the parent/guardian/caregiver/other*
(Print name)
Of _____ declare under penalty of perjury that the above-
(Print Student's name)
named student and his/her family reside at the address shown on the document indicated above and attached. I understand that **if my residency changes, I must notify the school within two weeks, provide new proof of residency and sign an updated form.** If I move outside the school district, an Interdistrict Attendance Permit must be filed in order to request continued attendance for this student.

Warning: Falsification of any information or document required for residency verification or the use of the address of another person without actually residing there may result in revocation of student enrollment.

Parent/Guardian/Caregiver/Other*
Signature: _____ Date: _____
***" other "indicates persons living with another family, which requires a second verification form**

FOR SCHOOLS USE ONLY:
The attached document shows the name and address of the person enrolling the above-named student. If not the parent, court papers are required for guardianship, foster placement documentation for foster parent, caregiver affidavit for caregiver.

School Official: _____ Date: _____
(Print name and provide signature)

830205(03/22)

School Year

Child's last name

Child's first name

Teacher

Room #

Grade

Chula Vista Elementary School District

New Student Registration

STUDENT INFORMATION

Legal Last Name: _____

Legal First Name: _____

Middle Name: _____

Residence Address: _____

_____

Home Telephone: (_____) _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary

Birthplace: City: _____ State: _____ Country: _____

Date 1st enrolled in a U.S. school: _____

Date 1st enrolled in a CA. public school: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino

Race: ***Mark primary with '1' and indicate others if needed.***

☐ African American ☐ Filipino ☐ Native American ☐ White

If Pacific Islander: ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Tahitian ☐ Other Pacific Islander

If Asian: ☐ Cambodian ☐ Chinese ☐ Indian ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian

Grade Enrolling for: _____ Academic Year: ____/____

School Enrolling for: _____

Has child ever attended a school in this District? ☐ YES ☐ NO

Name of prior school: _____

School Address (if other than CVESD): _____

_____

City _____ State _____ Zip _____

Phone or FAX Number: (_____) _____

List names of other siblings in home (list oldest child first):

1. _____ Birth Date: _____
2. _____ Birth Date: _____
3. _____ Birth Date: _____
4. _____ Birth Date: _____

PARENT / GUARDIAN INFORMATION

MOTHER/GUARDIAN/STEP PARENT (circle one)

Last Name: _____

First Name: _____

Address (if different from student): _____

_____

Primary Phone Number: (_____) _____

Additional Phone Number: (_____) _____

ACTIVE DUTY MILITARY: YES NO (circle one)

MILITARY VETERAN: YES NO (circle one)

Employer: _____

Work Phone Number: (_____) _____

E-Mail Address: _____

Parent/Guardian Education Level Check the one response that describes the highest education level of either parent/guardian:

☐ Graduate School / Post-graduate ☐ High School Graduate
☐ College Graduate ☐ Not a High School Graduate
☐ Some College (*includes AA degree)

FATHER/GUARDIAN/STEP PARENT (circle one)

Last Name: _____

First Name: _____

Address (if different from student): _____

_____

Primary Phone Number: (_____) _____

Additional Phone Number: (_____) _____

ACTIVE DUTY MILITARY: YES NO (circle one)

MILITARY VETERAN: YES NO (circle one)

Employer: _____

Work Phone Number: (_____) _____

E-Mail Address: _____

Parent/Guardian Education Level Check the one response that describes the highest education level of either parent/guardian:

☐ Graduate School / Post-graduate ☐ High School Graduate
☐ College Graduate ☐ Not a High School Graduate
☐ Some College (*includes AA degree)

Child lives with: ☐ Both Parents ☐ Mother only ☐ Father only ☐ Mother/Stepfather ☐ Father/Stepmother ☐ Grandparent(s) ☐ Foster Parent(s) ☐ Legal Guardian ☐ Caregiver

I am responsible for notifying my child's school of any changes. I certify that all the information on this form is true and correct. Falsification of information may be grounds for immediate cancellation of enrollment.

_____ _____ _____

Parent/Guardian Signature | Print Name | Date

THIS BOX FOR OFFICE USE ONLY **School:** _____ **Student ID:** _____ **Grade:** _____

Enrollment Date/Time: _____ **Teacher:** _____ **Room:** _____ **Pre-Reg:** _____

Birth Verification: _____ **Residency Verification Source:** _____ **2nd Family:** _____

SPED (circle one): YES NO **IEP:** _____ **Date:** _____ **Services:** _____

Custody Issues: _____ **Court Documents:** _____ **Caregiver Affidavit:** _____

Transfer (circle one): Interdistrict Zone **District/School of Residence:** _____

Chula Vista Elementary School District

EMERGENCY AND HEALTH INFORMATION

School:

Legal Last Name of Student | First | Date of Birth | Grade | Teacher

Home Address | Zip Code | Home Telephone

Mother's Name | Mother's Address | Employed By | Work Telephone

Father's Name | Father's Address | Employed By | Work Telephone

EMERGENCY INFORMATION: Provide name, address and telephone number of three adults other than parents who could take the child if he/she becomes ill at school and the parents are not available, preferably someone in the school area with a telephone and car. Your child will not be released to anyone except a parent / guardian or those adults listed below.

1. Name (relationship) | Address | Telephone

2. Name (relationship) | Address | Telephone

3. Name of Person (Childcare Provider) who cares for child after school | Address | Telephone

DISASTER PREPAREDNESS PLAN INFORMATION

In the case of a disaster (earthquake, fire, flood, bomb threat etc.) your child will not be released to anyone except those listed above.

Child's Doctor: Name | Address | Telephone

Medical Insurance Carrier: (HMO – MediCal – Private – None)

HEALTH INFORMATION

Does your child wear glasses or contacts? ☐ **Yes** ☐ **No** If yes, ☐ For close work only ☐ Distance only ☐ Both

Does your child have a hearing loss? ☐ **Yes** ☐ **No** If yes, ☐ For left ear only ☐ Right ear only ☐ Both

Does your child use hearing aids? ☐ **Yes** ☐ **No**

Does your child have a **Life Threatening Allergic Reaction?** ☐ **Yes** ☐ **No**

If yes, to what? Insect (type) _____ Food (type) _____ Other (type) _____

Does this life threatening allergy require an EpiPen (emergency injectable medication) that you will provide? ☐ **Yes** ☐ **No**

Has your child had **Asthma** within the past year?

Current medications: _____

Does your child need an inhaler at school? ☐ **Yes** ☐ **No**

Does your child **currently** have any of the following? (please check appropriate response)

☐ **Yes** ☐ **No** Heart disease

☐ **Yes** ☐ **No** Seizure disorders

☐ **Yes** ☐ **No** Activity limitations? If yes, please describe: _____

☐ **Yes** ☐ **No** Any operations? If yes, please describe: _____

☐ **Yes** ☐ **No** Frequent ear infections

☐ **Yes** ☐ **No** Diabetes

List any medications your child is taking on a regular basis: _____

Do any medications need to be administered at school? ☐ **Yes** ☐ **No** Name of medication: _____

Describe other health information that may affect your child at school _____

PRIVACY AND COMMUNICATION INFORMATION

Preferred language for papers sent home?	☐ **Spanish**	☐ **English**
May the District use your e-mail address to provide you with emergency news and updates?	☐ **Yes**	☐ **No**
May the District give your telephone number to the PTA or Parent Club?	☐ **Yes**	☐ **No**
Does your child have a current 504 Plan or an IEP (Individualized Education Plan)?	☐ **Yes**	☐ **No**
May your child's name or photo be released to the news media or for District publication purposes?	☐ **Yes**	☐ **No**

I HAVE REVIEWED AND UPDATED THE ABOVE EMERGENCY AND HEALTH INFORMATION.

Parent / Guardian Signature | Print Name | Date

PLEASE CALL THE SCHOOL NURSE IF YOUR CHILD HAS A CURRENT HEALTH PROBLEM

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
STUDENT DISASTER INFORMATION CARD

PLEASE PRINT

School: _____ Teacher_____

Child's Name: _____ Birthdate_____

Home Address: _____ Telephone_____

_____

Mother's (Guardian's) Name: _____ Day Phone: _____

Place of Employment: _____

Father's (Guardian's) Name: _____ Day Phone: _____

Place of Employment: _____

Adults other than Parent (Guardian) who may pick up child:

1._____ Day Phone: _____

2._____ Day Phone: _____

3._____ Day Phone: _____

List any health problems: _____

_____

List any medications taken on a regular basis: _____

Doctor's Name: _____Telephone: _____

Date: _____Parent's (Guardian's) Signature: _____

(infocard.doc) 814107 (3/18)

AUTHORIZATION FOR TREATMENT OF MINORS

PARENTS: This form signed by you authorizes emergency medical treatment for a minor child In case of necessity. Should it be necessary for you to be away from home, this form can authorize the person charged with the care of your child to act for you.

PLEASE PRINT

(I) (We), the undersigned, Parent(s)/Guardian(s) of_____
a minor, do hereby authorize employees of Chula Vista Elementary School District and/or any hospital located in San Diego County as agent(s) for the undersigned, in advance of any specific diagnosis, to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of any hospital in San Diego County, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and shall remain in effect, unless sooner revoked in writing to said agent(s), until the end of the current school year.

It is further understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, and we hereby do give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or surgeon in the exercise of his best judgement may deem advisable. We understand that neither Chula Vista Elementary School District, physician, surgeon, nor hospital Involved assumes any financial responsibility for exercising this action.

Parent/Guardian (Printed Name): _____

Signature: _____Date Signed: _____

It is helpful to have the following information in order to expedite paperwork necessary for treatment:

Insurance Carrier: _____

Name of Insured: _____

Policy Number: _____

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
84 East J Street • CV • 91910
STATE PRESCHOOL PROGRAM

ARRIVAL AND DEPARTURE FROM SCHOOL POLICY

It is very important to bring children to preschool and pick them up on time. The following is the Chula Vista State Preschool Program Policy.

It is the responsibility of the parents to provide transportation to and from school each day. Teachers will designate a location for parents and children to wait prior to class beginning. Each child must be signed in and out with the staff. The time of arrival/departure is to be noted on sign in/out sheet. Children will be released only to parents, legal guardians, or other persons authorized in writing to pick up their child. When you sign in and out, please use your full signature.

It is very important that parents bring and pick up their children on time. Please be aware of when class starts and ends and have your child arrive on time as well as have your child picked up on time each day. Arriving at school on time allows your child to understand the importance of school, be welcomed by staff, and adjust to the school day.

Teachers are not available to care for children after class ends. No one under 18 years of age can be designated to drop off or pick up a child. **Children repeatedly brought to school or picked up late will be dropped from the program.**

Children not picked up on time are caused undue distress and concern. Staff needs the brief time following the morning session to prepare for the afternoon class. Teachers often have other responsibilities following the afternoon class and cannot watch children remaining in the classroom.

If a child is not picked up at the ending time of his/her class or is late to school the following action will be taken.

The parent will be requested to sign a "Late Arrival/Pick Up Form". Receipt of **three (3) "Late Pick Up"** and/or receipt of **five (5) "Late Arrival"** forms in a year will result in a mandatory parent meeting with the Preschool Coordinator to determine possible termination of preschool services for your child.

Your cooperation is necessary in assuring the well being of your child. Please assist us by being punctual to and from school and please note: **NO ONE UNDER 18 YEARS OF AGE IS ALLOWED TO DROP OFF OR PICK UP A PRESCHOOLER.**

I have read the above policy and have received a copy for my records.

Parent Signature: Date:

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

84 EAST J STREET ● CHULA VISTA, CALIFORNIA 91910 ● 619 425-9600

RECORD OF PRIOR SCHOOL PROGRAMS AND SPECIAL SERVICES

Student Name:		ID #
School:	Grade:	Teacher:
Relationship to student: ☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify)		

If your child is registering in the Chula Vista Elementary School District for the first time:

1. Does your child have a current IEP (Individualized Education Plan)?

   ☐ Yes *If yes, please attach a copy of the most current IEP*

   ☐ No

2. Does your child have a current 504 Plan (Accommodations for Specific Disabilities)?

   ☐ Yes *If yes, please attach a copy of the most current 504 Plan*

   ☐ No

Special Education Program

(Please check boxes that apply, or *None of the above* to indicate that none apply).

☐ Speech/Language Therapy
☐ RSP (Resource Specialist Program)
☐ Special Education Special Day Class
☐ Specialized Behavioral Support (ABA, 1:1 Aide, NPS, etc.)

Other Instructional Programs

☐ Reading Support Program
☐ Gifted and Talented Education (GATE)
☐ Other Instructional Program Support _____
_____

☐ None of the above

Parent Signature: _____ Date: _____

Email Address: _____ Phone (Cell): _____

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

HOME LANGUAGE SURVEY

Name of Student:_____
(Last Name) (First Name) (Middle Name)

Age of Student: _____ Grade Level: _____ School: _____

Directions to Parents and Guardians:
California Education Code, section 52164.3 contains legal requirements which directs schools and districts to assess the English proficiency of students if there is a language other than English spoken in the home. This information is critical in order to provide the instructional program, services and support for student success.

The process begins with parents completing the Home Language Survey. The Home Language Survey is completed only once for students in grades TK to 12 in California. If a Home Language Survey was previously completed, then schools and districts will honor the original Home Language Survey on file.

The Home Language Survey assists in determining the language(s) spoken in the home of each student, and it also determines if a student's proficiency in English should be tested. All students whose primary language is not English and who are obtaining a California student identification for the first time will take the Initial English Language Proficiency Assessment for California (Initial-ELPAC). *The goal is to provide students who are learning English as a second language the timely support and resources to be successful in school.*

We appreciate your support in accurately completing the Home Language Survey so we can effectively meet the learning needs of your child. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

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

2. Which language does your child most frequently speak at home? _____

3. Which language do you (the parents or guardians) most frequently use when speaking with your child? _____

4. Which language is most often spoken by adults in the home? (parents, guardians, grandparents, or any other adults) _____

By signing this form, I understand my child may be assessed to determine English Language Proficiency and provide services that support my child's learning.

_____
Print Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

Chula Vista Elementary School District
84 East J St • Chula Vista, CA 91910 • (619) 425-9600

IMPORTANT HEALTH ISSUES

Please complete this form first

Student's Name: _____ *Last* *First* *Middle Initial*	School Enrolling for:
	Grade Enrolling for:
Parent / Guardian Name: _____ E-mail address: _____	Home phone: _____ Cell phone: _____

Will your child require special assistance at school for any of the following reasons?

☐ Yes ☐ No *allergy requiring medication — *Emergency medication:* _____
☐ Yes ☐ No *blood disorder — *Student is severely allergic to:* _____
☐ Yes ☐ No *cancer (history of)
☐ Yes ☐ No *catheterization
☐ Yes ☐ No *diabetes
☐ Yes ☐ No *heart condition (current)
☐ Yes ☐ No *intravenous catheter or port
☐ Yes ☐ No *medical limitations to physical activities
☐ Yes ☐ No *seizures
☐ Yes ☐ No *swallowing difficulties
☐ Yes ☐ No *tube feeding
☐ Yes ☐ No *wears diapers
☐ Yes ☐ No *wets or soils clothing with urine or stool
☐ Yes ☐ No *wheelchair
☐ Yes ☐ No asthma
☐ Yes ☐ No requires respiratory assistance; such as the Nebulizer machine (Pulmo-Aide)
☐ Yes ☐ No arthritis
☐ Yes ☐ No braces or prosthetics (arms, legs)
☐ Yes ☐ No crutches
☐ Yes ☐ No Does your child have a current 504 Plan or an IEP?
☐ Yes ☐ No Does your child require ongoing medication? *Name of med* _____
Med given at home? _____ *Med to be administered at school?* _____
☐ Yes ☐ No Does your child have other health issues? *If yes, please explain:* _____
_____

If you have indicated 'yes' to any of the above <u>health issues marked with an asterisk(*)</u>, your child will <u>not</u> be allowed to start school until the School Nurse is consulted. Please complete and sign a HIPAA form, available in the school office, if you have checked yes to a health issue marked with an asterisk(*).

Parent / Guardian Signature _____ Date _____ School Nurse Signature _____

DO NOT REMOVE FROM CUMULATIVE FOLDER

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: DEPARTMENT OF SOCIAL SERVICES
Community Care Licensing

Licensing Office Address: 7575 Metropolitan Drive, Suite 110
San Diego, CA 92108

Licensing Office Telephone #: (619) 767-2200

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

8. Receive, from the licensee, the Caregiver Background Check Process form.

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

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

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

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

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
State Preschool Program
Name of Child Care Center
84 East "J" Street
Chula Vista, CA 91910

_____ _____
Signature (Parent/Authorized Representative) Date

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

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

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(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:

COMMUNITY CARE LICENSING

NAME

MISSION VALLEY DISTRICT OFFICE

ADDRESS

7575 METROPOLITAN DR SUITE 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
SAN DIEGO	92108-4402	(619) 767-2200

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

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

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

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
CHULA VISTA ELEMENTARY SCHOOL DISTRICT	84 E J STREET, CHULA VISTA CA 91910

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

84 East J Street • Chula Vista • CA 91910
Phone (619) 425-9600 • Fax (619) 427-0463 • www.cvesd.org

MEDIA RELEASE AUTHORIZATION

To the Parents of:	
School:	Teacher:
Grade:	Date of birth:

From time to time, the Chula Vista Elementary School District has the opportunity to participate in promotional activities featuring students, schools and/or District programs. Please review and sign this form to authorize your child's participation as described below.

I authorize the District to:

☐ Duplicate or reproduce my child's work in multiple media formats, including but not limited to print, electronic, or web-based publications.	Additional description (to be completed by the school or District):
☐ Allow media agencies and/or the District to interview, photograph, videotape, and/or publish information about my child in multiple media formats, including but not limited to print, electronic, or web-based publications.	Additional description (to be completed by the school or District):

Please complete this form and return it to your child's teacher at your earliest convenience.

I, THE PARENT/GUARDIAN OF THE CHILD NAMED HEREIN, HAVE READ THE INFORMATION PRINTED ABOVE AND AUTHORIZE THE RELEASE OF INFORMATION/WORK/PHOTOS CONCERNING MY CHILD UNDER THE CONDITIONS OUTLINED.

Printed Name:_____ Relationship to Child _____

_____
Signature Date

_____
Address

( ) -
_____
Phone Number(s) Email address

For additional information, contact your school or District Communications Officer at (619) 425-9600 Ext. 1328

Chula Vista Elementary School District
State Preschool Office
Family Intake Assessment

Date: _____ **Child's name:** _____ **Date of birth:** _____

If you would like more information on any of the following programs, please mark the appropriate box.

Services needed:

- ☐ Family Support and Advocacy
- ☐ Parenting resources/support
- ☐ Health insurance enrollment assistance
- ☐ Employment resources
- ☐ Emergency food
- ☐ Referrals for counseling
- ☐ Pregnant/parenting teen support
- ☐ Community closet-clothing for family
- ☐ Information and referral to other agencies
- ☐ Application for SDGE CARE program
- ☐ CalFresh application assistance
- ☐ Adult education classes
- ☐ Paperwork assistance (simple)
- ☐ Health and safety information
- ☐ Volunteer/community service opportunities
- ☐ *Not interested*

Parent Signature: _____ **Date:** _____

Resource Provided: *Family Resource Center brochure and contact information.* Intake certified by: _____

Family received FRC brochure: ☐ Yes ☐ No

Family gave consent to be referred to FRC: ☐ Yes ☐ No

CALIFORNIA DEPARTMENT OF EDUCATION
Form CD 9600A, (Rev. 01/04)

Child Care Data Collection
Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who receive child care assistance. The information will be reported to the California Department of Education (CDE) and then to HHS. The information will be used for research on the status of child care in the United States and will provide valuable data to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, the Legislature, other governmental agencies, or the public.

To ensure that children and families receiving child care services are counted only once, HHS and CDE are requesting the Social Security Number of the head of the family unit receiving child care assistance. If you do not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated in Section 98.71(a)(13) of *Title 45* of the *Code of Federal Regulations*, *Education Code* Section 8261.5, and Section 18070 of *Title 5* of the *California Code of Regulations*. Your decision to provide your Social Security Number is voluntary.

I have been informed of the way my Social Security Number will be used. I understand that if I do not wish to give my number, I can still receive child care assistance.

☐ YES, my Social Security Number may be used: _____-_____-_____

☐ NO, I do not wish to give my Social Security Number for this purpose.

_____ _____
Signature of the Head of Household Date

_____
Type or Print Name

You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Early Education and Support Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

❖ ***FORM NEEDS TO BE SIGNED BY WORKING PARENT***

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable information, as set forth below, consistent with California and Federal laws (e.g. HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

I, _____, parent/guardian of _____, do hereby authorize my employer(s):

(1) _____
Phone: _____
Address: _____
_____

(2) _____
Phone: _____
Address: _____
_____

To provide information regarding my employment (gross wages and work hours) to:

Chula Vista Elementary School District
State Preschool Program
84 East "J" Street
Chula Vista, California 91910
(619)425-2362 or (619)425-9600 Ext. 1510

Requested information shall be limited to wages and work hours of contract, for the purpose of confirming/establishing my family's need to receive state subsidized child care or child development services.

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one-year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand I have the following rights with respect to this Authorization: I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivery to the District. My revocation will be effective upon receipt, but will not be in effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand the District will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain State subsidized child care or child development services.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Student Area Code and Telephone Number

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
State Preschool Program

Sworn Statement

Child's name: _____

Failure to report correct information and ALL facts may result in termination of preschool services.

Please complete the statement that best applies to you.

A) I_____declare I am a parent who **DOES NOT** work (housewife/stay home dad) and **I DO NOT** have any other source of income but my _____.

B) I_____ declare that:

□ I am living with _____, relationship _____; or
(relatives or roommate)

□ My spouse and I are living with _____, relationship _____;
(relatives or roommate)

Do you share rent? Yes□ No□ & Do you pay utilities? Yes□ No□

ABSENT PARENT INFORMATION (If applicable)

Name of absent parent: _____Cell #_____

Do you receive child support? Yes☐ No☐ How much per month: $_____

Is child support court mandated? Yes☐ No☐ Is child support verbal agreement? Yes☐ No☐

Do you have shared custody? Yes☐ No☐ Is there any restraining order? Yes☐ No☐

I declare under penalty of perjury that the information contained in this statement is true, correct and complete.

_____ _____
Parent/guardian signature Date

CHULA VISTA ELEMENTARY SCHOOL DISTRICT
84 E J Street, Chula Vista, Ca. 91910

Housing Questionnaire

School Name: _____

The information provided below will ensure that Chula Vista Elementary School District determines which services you and/or your child may be eligible to receive. This information will be kept confidential and only shared with appropriate district and school site staff.

Presently, are you and/or your family living in any of the following situations? *Check all that apply*.

- ❑ 1.Staying in a shelter (family, domestic violence, youth, etc.) or FEMA trailer
- ❑ 2.Sharing housing with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing or similar reason (*do **NOT** check if you are sharing housing with others as a mutual decision for benefit of both parties*)
- ❑ 3.Temporary living in a hotel or motel
- ❑ 4.Living in a car, park, campground, abandoned building, RV, trailer, or other inadequate fixed accommodations (i.e., lack of water, electricity, or heat)
- ❑ 5.I am a student under the age of 18 who is living on my own apart from parent/legal guardian
- ❑ 6.None of the above

By selecting any of the items other than #6 above, your child may be identified as a homeless child or youth. Additionally, you may qualify for benefits under the McKinney-Vento Homeless Assistance Act and may be contacted by a District Social Worker or District employee.

The undersigned parent/guardian certifies that the information provided above is correct and accurate. Falsification of records may result in denial or revocation of enrollment of the students named below.

_____ _____ _____
Print Name *Signature* *Date*

_____ (_____)_____
Address *Phone*

Your child(ren) may have the right to: *Email*_____

- Immediately enroll in the school they last attended or the local school where you are currently staying, even if you do not have the documents typically required for enrollment
- Continue to attend the school of origin
- Receive transportation if needed, and including free meals
- Receive full protection and services provided under all federal and state laws, as it relates to homeless youth and their families

Please list all children attending the Chula Vista Elementary School District and living with you

Name	M/F/NB	Birthdate	Grade	School

If you have any questions about these rights, please contact the District Student Placement Department at (619) 425-9600 ext. 181570

PLEASE HAVE DOCTOR COMPLETE. RETURN TO TEACHER WITHIN 30 DAYS OF HIS/HER FIRST DAY OF SCHOOL. EL MEDICO TIENE QUE LLENAR LA FORMA. FAVOR DE ENTREGARSELO AL MAESTRO(A). TIENE 30 DIAS DESPUES DEL PRIMER DIA DE CLASES PARA HACERLO.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

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

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

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

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

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

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

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

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

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

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

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
☐ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

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

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