

WELCOME TO PRESCHOOL

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

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

- Please fill out all the forms and write clearly.
- Use first and last name.
- Be sure to sign and date were indicated.
- Do your best to complete all the forms. If you have any questions, please just give us a call.
- The VERIFICATION OF RESIDENCY form needs to be completed by the parent whose name appears in the document that is going to be used as proof of residency.
- Please carefully read the SWORN STATEMENT and complete only what applies to your case. 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 person who is working. If both parents are working, each one must complete one.
- The PHYSICIANS REPORT (yellow 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.

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** from the following list must be provided. Said 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 or statement ____ Homeowner's association billing statement

____ New rental contract/lease, **or** current payment receipt w/landlord contact info

____ Letter on apartment complex or mobile home park letterhead, signed by the landlord, stating that parent/guardian/caregiver/ lives there

____ Power Bill ____ Water/Sewer Bill ____ Trash Bill ____ Cable Bill ____ Landline Phone Bill

____ 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-named
(Print student's name)

student and his/her family reside at the address shown on the document indicated above and attached. I understand that **if 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 SCHOOL 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)

School Year

Child's last name

Child's first name

Teacher

Room #

Grade

Immunization records are online!

Chula Vista Elementary School District uses the California Immunization Registry (CAIR) to store immunization records for many of their students. By using this system, the school can make sure that your children's immunization records can be easily located by a school nurse or health care provider when you change schools, doctors, or during a disease outbreak, or natural disaster. Once the record is in CAIR, then you will be able to access it in the future through an online registration process at <http://www.sandiegoimmunizationregistry.org/mraccess/login.jsp>

Chula Vista Elementary School District staff enter immunization records into the centralized, secure, and confidential database. Please return this completed form and a copy of the individual's immunization record to your school.

For more information, visit the SDIR Website at:

www.sdiz.org/CAIR-SDIR/index.html or call the SDIR Help Desk at (619) 692-5656 .

Please complete the information below. **Fill out additional form(s) if submitting more than one individual's immunization record.**

Please print clearly and include your phone number in case we need to call you!

PARENT/GUARDIAN	STUDENT
Name:	Last name:
Street Address:	First name:
City:	Date of Birth:
Zip Code:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Email:	Fields below will help locate the immunization record in the future:
Home Telephone:	
Relationship to student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other [specify]	
	<input type="checkbox"/> Mother's maiden name:
	<input type="checkbox"/> Medical record # (optional)
	Office use only
	<input type="checkbox"/> ENTERED in SDIR DATE: ___/___/___ STAFF INITIALS _____
Signature of Parent/Guardian: _____	

Immunization records are **only shared** with public health, participating health care providers, schools, childcare and other authorized programs that require the review of immunization records for enrollment. Check here only if you do not want the record to be shared. ☐ Initials: _____

STUDENT INFORMATION	PARENT / GUARDIAN INFORMATION
Legal Last Name: _____ Legal First Name: _____ Middle Name: _____ Residence Address: _____ _____ Home Telephone: (____) _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ Birthplace : City: _____ State: _____ Country: _____ Date 1st enrolled in a U.S. school: _____ Date 1st enrolled in a CA. public school: _____ Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino Race: <i>Mark primary with '1' and indicate others if needed.</i> <input type="checkbox"/> African American <input type="checkbox"/> Filipino <input type="checkbox"/> Native American <input type="checkbox"/> White <div style="border: 1px solid black; padding: 2px; margin: 2px 0;"> If Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander </div> <div style="border: 1px solid black; padding: 2px; margin: 2px 0;"> If Asian: <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian </div> Grade Enrolling for: _____ Academic Year: _____ / _____ School Enrolling for: _____ Has child ever attended a school in this District? <input type="checkbox"/> YES <input type="checkbox"/> 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: _____	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: _____ 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: _____ Child lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Caregiver Parent/Guardian Education Level Check the <u>one</u> response that describes the highest education level of either parent/guardian: <input type="checkbox"/> Graduate School / Post-graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> College Graduate <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> Some College (*includes AA degree)

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: _____		2 nd Family: _____	
SPED (circle one): YES NO IEP: _____	Date: _____	Services: _____		
Custody Issues: _____	Court Documents: _____	Caregiver Affidavit: _____		
Transfer (circle one): Interdistrict Zone District/School of Residence: _____				

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)

<input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent ear infections
<input type="checkbox"/> Yes <input type="checkbox"/> No Seizure disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No Activity limitations? If yes, please describe: 	
<input type="checkbox"/> Yes <input type="checkbox"/> No Any operations? If yes, please describe: 	

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: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> 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

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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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
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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: _____			School Enrolling for: _____
_____ <i>Last</i>	_____ <i>First</i>	_____ <i>Middle Initial</i>	Grade Enrolling for: _____
Parent / Guardian Name: _____			Home phone: _____
E-mail address: _____			Cell phone: _____

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

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

If you have indicated 'yes' to any of the above health issues marked with an asterisk(*), your child will not 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 _____

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.

DEPARTMENT OF SOCIAL SERVICES
Licensing Office Name: Community Care Licensing
7575 Metropolitan Drive, Suite 110
Licensing Office Address: 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 896 (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

SAN DIEGO

ZIP CODE

92108-4402

AREA CODE/TELEPHONE NUMBER

(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)

CHULA VISTA ELEMENTARY SCHOOL DISTRICT

(PRINT THE ADDRESS OF THE FACILITY)

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:

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

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

**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

❖ **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) _____	(2) _____
Phone: _____	Phone: _____
Address: _____	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

PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

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

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

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

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

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

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

(TODAY'S DATE)

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

Problems of which you should be aware:

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

Dental: _____

Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

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

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

SCREENING OF TB RISK FACTORS (listing on reverse side)

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

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

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☒ Physician ☒ Physician's Assistant ☒ Nurse Practitioner