

**Packet return: Monday-Friday
8:30-10:30 am and 12:30-3:30 pm**

**Regrese el paquete: Lunes a Viernes
8:30-10:30 am y 12:30-3:30 pm**

2021-2022

ENROLLMENT REGISTRATION INFORMATION SHEET

Mike Choate Early Childhood Education Center

(760) 695-9607

You will need:

1. **Registered Birth Certificate and Birth Certificate(s) of all dependent children under 18 in the household** - Souvenir birth announcements from the hospital and notification of Registration of Birth are not legal documents.
2. **Current Immunization Record** – Up to date according to state law. See attached Parent’s guide for requirements. Must be properly signed and dated.
3. **Current Health Check Up** – or proof of scheduled appointment. See attached form.
4. **Proof of Residency** – Example: Deed, rent receipt, utility bill. License or ID not accepted.
5. **Picture I.D** of parent or legal guardian registering the child.
6. **Proof of Income** – Parent’s income for 30 consecutive days and any other income, including pay stubs, cash aid, food stamps, Section 8, pension, unemployment and/or proof of child support, if applicable. *If you are self-employed, please call preschool office in advance for information on required documentation.*

***You must have all these items and this packet completed before we can accept this packet to apply.**

Necesitara lo siguiente para registrar a su hijo/a:

1. **Acta de nacimiento de todos los niños menores de 18 años en la familia** – Certificado del hospital no es un documento legal.
2. **Comprobante de Vacunas**- Actualizada de acuerdo a la ley estatal. Vea la guía de requisitos de vacunas que esta incluida. Debe de tener todas las vacunas con fecha y firma apropiada.
3. **Examen de Salud** – Reciente o comprobante de una cita. Ver formulario adjunto.
4. **Comprobante de Residencia** – Ejemplos: Recibo de renta o pago mensual de casa, cuenta de utilidades (gas, electricidad, agua). No se acepta licencia o identificación como comprobante.
5. **Identificación con foto** de madre, padre or tutor registrando al niño/a.
6. **Comprobantes de un mes de salario con fecha reciente al día de inscripción** y cualquier otro ingreso incluyendo talones de cheque, asistencia social, estampillas de comida, Sección 8, pensión, desempleo, y/o manutención infantil, si es aplicable. *Si tiene negocio propio o recibe pago en efectivo, por favor llame a la oficina para información sobre documentos que debe presentar.*

*** Necesita tener todos estos documentos y este paquete completo antes que podamos aceptar su solicitud para aplicar .**

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER 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
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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?
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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*
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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?

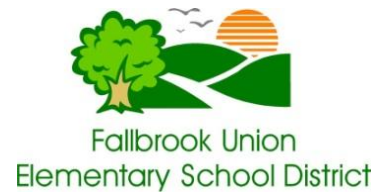
REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE

DATE

FOR OFFICE USE ONLY

School: _____ Start Date: _____ Teacher: _____
 INTERdistrict Yes No INTRAdistrict: Yes No GATE Yes No
 DOB Verified: _____ Migrant Card _____ Date: _____
 Immunizations: Complete Incomplete Exempt
 Verified By: _____ Date: _____ Student ID# _____



Preschool Student Registration Form

	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Student Legal Last Name	Legal First	Legal Middle	Grade
Date of Birth	Birth Place	Birth State	Birth Country

Has this student:

Attended Fallbrook schools before? Yes No Been retained? Yes No If yes, grade? _____
 Attended Preschool? Yes No If yes, When? _____ Where? _____
 Attended a California Public School? Yes No If yes Where? _____
 Ever received Special Education Services? Yes No
 Ever received 504 accommodations? Yes No
 Ever been qualified for GATE? Yes No
 Ever been placed on a SARB Contract? Yes No
 Ever been previously suspended and/or expelled or is he/she currently recommended for expulsion? Yes No
 What date did this student first enter a U.S. School? _____
 Does anyone in your household work, or has anyone ever worked in seasonal or temporary work related to agriculture (such as field work), food processing (canneries or packing houses), fishing, lumbering or dairy work in the last three years?
 Yes No
 In what language would you like to receive school communications? English Spanish

As mandated by federal and state law, please answer the following questions to identify this student's ethnicity and race. This information will only be used for reporting total counts of students and will not be released in a personally-identifiable form

Is this student's ethnicity Hispanic or Latino? Yes No

Please mark one or more of the following boxes to indicate the student's race.

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian-Chinese | <input type="checkbox"/> Asian-Japanese |
| <input type="checkbox"/> Asian-Korean | <input type="checkbox"/> Asian-Vietnamese | <input type="checkbox"/> Asian-Indian |
| <input type="checkbox"/> Asian-Laotian | <input type="checkbox"/> Asian-Cambodian | <input type="checkbox"/> Asian-Hmong |
| <input type="checkbox"/> Asian-Other | <input type="checkbox"/> Pacific Islander-Hawaiian | <input type="checkbox"/> Pacific Islander-Guamanian |
| <input type="checkbox"/> Pacific Islander-Samoan | <input type="checkbox"/> Pacific Islander-Tahitian | <input type="checkbox"/> Pacific Islander-Other |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Black | <input type="checkbox"/> White |

Primary Address

Home Address (Street) _____ City _____ State _____ Zip Code _____

Primary Phone Number: (_____) _____

Residence Information (federally mandated by NCLB) – where is your child currently living?

- | | | |
|--|--|---|
| <input type="checkbox"/> Single Family Permanent Housing | <input type="checkbox"/> Doubled-up (temporarily sharing housing due to economic hardship or loss) | |
| <input type="checkbox"/> Motel/Hotel | <input type="checkbox"/> Unsheltered (car/campsite) | <input type="checkbox"/> Shelter/Transitional Housing Program |
| <input type="checkbox"/> Foster Home | <input type="checkbox"/> Other (please specify) _____ | |

Name of Last School Attended: _____

Address: _____
Street
City
Zip

Phone Number _____ Fax: _____

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

- CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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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: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

Signature _____

Physician Physician's Assistant Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

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

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

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), domestic partner(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/DOMESTIC PARTNER/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

DETACH HERE

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

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

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

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(DATE)

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: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

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

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

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

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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

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

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

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

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

_____ HOME ADDRESS

_____ HOME PHONE
()

_____ WORK PHONE
()

PARENTS' GUIDE TO IMMUNIZATIONS REQUIRED FOR PRE-KINDERGARTEN (CHILD CARE)



Starting July 1, 2019

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

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

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

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

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



Mike Choate Early Childhood Development Center
Preschool Program Eligibility Questionnaire

Completion of this application does not guarantee your child's enrollment. We will enter the information on this questionnaire to help us determine program eligibility. Admission to this program is not based solely on state income guidelines, but it is a factor that must be considered based on funding. Other eligibility factors include English Learner status and age. Incomplete questionnaires CANNOT be processed and will be returned. We must have this document on file for a student to be enrolled in our preschool program.

Family Information:

Guardian A: Name of (Parent-guardian-foster parent)

Guardian B: Name of (Parent-guardian-foster parent)

Student Name

Student Date of Birth

Today's Date

Home Language Survey:

Directions: Please check a response for each of the following questions and indicate other languages if applicable.

English Spanish Other:

- 1. What language did your child learn when he/she first began to speak?
2. What language does your child most frequently use at home?
3. What language do you use most frequently to speak to your child?
4. What language do the adults at home most often speak?

Sources of Income: Please list your average monthly gross income (before deductions) Decline to state

The following applies to Guardian A

The following applies to Guardian B

Family earnings (gross) \$
Pensions/ Retirement \$
Social Security/Disability \$
Child support/Alimony \$
Welfare benefits \$
Other income \$

Family earnings (gross) \$
Pensions/ Retirement \$
Social Security/Disability \$
Child support/Alimony \$
Welfare benefits \$
Other income \$

Total Family Income (guardian A + B): \$ # of dependents in household:

Office Use Only:
Title I qualified EL qualified Age Gen



Mike Choate Early Childhood Development Center Cuestionario de Elegibilidad para el Programa Prescolar

El llenar esta solicitud no garantiza la inscripción de su hijo(a). Tomaremos en cuenta la información en este cuestionario para determinar la elegibilidad para el programa. El ingreso a este programa no está basado únicamente en las guías estatales de ingreso monetario, pero es un factor que se debe de considerar dado a la financiación. Otros factores que se consideran son el idioma y la edad. Los cuestionarios que no se llenen completamente NO serán procesados y se les regresarán. Nosotros debemos tener este documento archivado para poder inscribir al estudiante en nuestro programa prescolar.

Información Familiar:

Tutor A: Nombre del (padre-tutor-padre de crianza)

Tutor B: Nombre del (padre-tutor-padre de crianza)

Nombre del Estudiante

Fecha de Nacimiento del Estudiante

Fecha de Hoy

Encuesta del Idioma en el Hogar:

Instrucciones: Favor de marcar una respuesta para cada una de las siguientes preguntas y anote el idioma cuando corresponda.

Inglés Español Otro(s) idioma(s):

- 5. ¿Qué idioma habló su niño(a) cuando empezó a hablar? Inglés Español _____
- 6. ¿Qué idioma usa su niño(a) con más frecuencia en el hogar? Inglés Español _____
- 7. ¿Qué idioma usa con más frecuencia cuando habla usted con su hijo(a)? Inglés Español _____
- 8. ¿Qué idioma hablan los adultos en el hogar la mayor parte del tiempo? Inglés Español _____

Fuentes de Ingreso: Favor de indicar el promedio de su ingreso mensual en bruto (antes de los impuestos)

Me niegó a declararlo

Lo siguiente aplica al **tutor A**

Sueldo familiar (en bruto) \$ _____

Pensiones/ retiro \$ _____

Seguro social/incapacidad \$ _____

Pensión alimenticia/niño u adulto \$ _____

Asistencia social \$ _____

Otros ingresos \$ _____

Lo siguiente aplica al **tutor B**

Sueldo familiar (en bruto) \$ _____

Pensiones/ retiro \$ _____

Seguro social/incapacidad \$ _____

Pensión alimenticia/niño u adulto \$ _____

Asistencia social \$ _____

Otros ingresos \$ _____

Total de Ingresos familiares (tutor A + B): \$ _____ Núm. de dependientes en el hogar: _____

Para uso de la oficina solamente:
Title I qualified _____ EL qualified _____ Age _____ Gen _____

Governing Board

Darryl Buntin

Patty de Jong

Lisa Masten

Patrick Rusnell

Siegrid Stillman



Minor/Student Release Form

Students who attend *Fallbrook Union Elementary School District* are occasionally asked to be a part of school publicity, publications, newspapers, and/or public relations activities. To guarantee student privacy and ensure your agreement for your students to participate, the *Fallbrook Union Elementary School District* asks that you sign and return this form to the school for each of your students. This includes Yearbook and class photos.

The form referenced below indicates approval for the student's name, picture, art, written work, voice, verbal statements or portraits (video or still) to appear in the *Fallbrook Union Elementary School District* publicity and/or publications, videos, or on the District or school website. Pictures and articles about school activities may also appear in local newspapers or district publications.

Agreement

Student and Parent/Guardian release to Fallbrook Union Elementary School District

Fallbrook Union Elementary School District agrees that the student's name, picture, art, written work, voice, verbal statements, portraits (video or still) will only be used for public relations, public information, school promotion, and instruction. With respect to publication in school web pages, the *Fallbrook Union Elementary School District* further agrees that:

- Children and young people under the age of 18 will not be identified in personal details other than first name, or first name and last name initial. Full names will not be used with pictures.
- Where text on a page is not associated with an accompanying image, only first names or first name and last name initial of students will be used.
- *Fallbrook Union Elementary School District* will immediately comply with any request by a parent/legal guardian for the removal of specific photographs featuring their child or references to their child's name.

Student and Parent/Guardian understand and agree that:

- No monetary consideration shall be paid
- Consent and release have been given freely

Yes, I give my consent

No, I do NOT give my consent

I give my consent for Yearbook and class photos only.

If the Student and/or Parent/Guardian wish to rescind this agreement they may do so at any time with written notice.

Student's Name PRINT: _____

Parent/Guardian Signature: _____ Date: _____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER 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
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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	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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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*
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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

Parent/Guardian Information

Contact #1

Relationship _____				Full Name _____				Home Phone _____				Work Phone _____			
Text messages OK? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Cell phone _____												Email _____			
Mailing Address: _____															
Parent Education Level:															
<input type="checkbox"/> Not a High School Graduate				<input type="checkbox"/> High School Graduate				<input type="checkbox"/> Some College							
<input type="checkbox"/> College Graduate				<input type="checkbox"/> Graduate/Post Grad Training				<input type="checkbox"/> Decline to state/Unknown							
Parent contact allowed:															
<input type="checkbox"/> Contact Allowed				<input type="checkbox"/> Educational Rights				<input type="checkbox"/> Has Custody							
<input type="checkbox"/> Lives with				<input type="checkbox"/> Mailings allowed											
Active Military? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes: Branch _____				Rank: _____							
				Bldg # _____				Duty Station _____							

Contact #2

Relationship _____				Full Name _____				Home Phone _____				Work Phone _____			
Text messages OK? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Cell phone _____												Email _____			
Mailing Address: _____															
Parent Education Level:															
<input type="checkbox"/> Not a High School Graduate				<input type="checkbox"/> High School Graduate				<input type="checkbox"/> Some College							
<input type="checkbox"/> College Graduate				<input type="checkbox"/> Graduate/Post Grad Training				<input type="checkbox"/> Decline to state/Unknown							
Parent contact allowed:															
<input type="checkbox"/> Contact Allowed				<input type="checkbox"/> Educational Rights				<input type="checkbox"/> Has Custody							
<input type="checkbox"/> Lives with				<input type="checkbox"/> Mailings allowed											
Active Military? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes: Branch _____				Rank: _____							
				Bldg # _____				Duty Station _____							

Other Children in the Home

Name _____ M F DOB _____ Name _____ M F DOB _____
Name _____ M F DOB _____ Name _____ M F DOB _____

I certify that all the information on this form is true and correct.

Parent/Guardian Signature

Date

At the time of registration, please provide documentation showing student's current address for proof of residency including but not limited to:

Driver's License/I.D. Card (current address)

Deed/Escrow papers/Rent Receipt/Property Tax Bill

Utility Bill/Receipt for Service Start-Up

Moving Receipt/Delivery Receipt

Bank Account Checkbook

District Affidavit Declaration of Residency