Fallbrook Union
Elementary School District

**Packet return: Monday or Wednesday**
**10:00 am-1:00 pm**
**Regrese el paquete: Lunes o Miércoles**
**10:00 am-1:00 pm**

# 2020-2021

## 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.

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*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 |
|---|---|---|---|---|---|
| ☐ 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 |
|---|---|

**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#_____

Fallbrook Union Elementary School District

# Preschool Student Registration Form

☐ Male ☐ 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.**

| | | |
|---|---|---|
| ☐ American Indian or Alaska Native | ☐ Asian-Chinese | ☐ Asian-Japanese |
| ☐ Asian-Korean | ☐ Asian-Vietnamese | ☐ Asian-Indian |
| ☐ Asian-Laotian | ☐ Asian-Cambodian | ☐ Asian-Hmong |
| ☐ Asian-Other | ☐ Pacific Islander-Hawaiian | ☐ Pacific Islander-Guamanian |
| ☐ Pacific Islander-Samoan | ☐ Pacific Islander-Tahitian | ☐ Pacific Islander-Other |
| ☐ Filipino | ☐ Black | ☐ 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?

☐ Single Family Permanent Housing ☐ Doubled-up (temporarily sharing housing due to economic hardship or loss)
☐ Motel/Hotel ☐ Unsheltered (car/campsite) ☐ Shelter/Transitional Housing Program
☐ Foster Home ☐ 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 |
|---|---|
| | |

## TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

| DATE OF ADMISSION | DATE LEFT |
|---|---|
| | |

# 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.

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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)

CDPH

## 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**<br>**1 DTaP**<br>**1 Hep B**<br>**1 Hib** |
| **4-5 Months** | **2 Polio**<br>**2 DTaP**<br>**2 Hep B**<br>**2 Hib** |
| **6-14 Months** | **2 Polio**<br>**3 DTaP**<br>**2 Hep B**<br>**2 Hib** |
| **15-17 Months** | **3 Polio**<br>**3 DTaP**<br>**2 Hep B**<br>**1 Hib*** (on or after 1st birthday)<br>**1 Varicella**<br>**1 MMR** (on or after 1st birthday) |
| **18 Months–5 Years** | **3 Polio**<br>**4 DTaP**<br>**3 Hep B**<br>**1 Hib*** (on or after 1st birthday)<br>**1 Varicella**<br>**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

Fallbrook Union Elementary School District
321 N. Iowa Street Fallbrook, CA 92028-2108 760.731.5400 www.fuesd.org
Candace Singh
*Superintendent*

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

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

Office Use Only:
Title I qualified _____ EL qualified_____ Age_____ Gen_____

Fallbrook Union Elementary School District
321 N. Iowa Street Fallbrook, CA 92028-2108 760.731.5400 www.fuesd.org
Candace Singh
*Superintendent*

# 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? | ☐ | ☐ | _____ |
| 6. ¿Qué idioma usa su niño(a) con más frecuencia en el hogar? | ☐ | ☐ | _____ |
| 7. ¿Qué idioma usa con más frecuencia cuando habla usted con su hijo(a)? | ☐ | ☐ | _____ |
| 8. ¿Qué idioma hablan los adultos en el hogar la mayor parte del tiempo? | ☐ | ☐ | _____ |

**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** | | Lo siguiente aplica al **tutor B** | |
|---|---|---|---|
| Sueldo familiar (en bruto) | $_____ | Sueldo familiar (en bruto) | $_____ |
| Pensiones/ retiro | $_____ | Pensiones/ retiro | $_____ |
| Seguro social/incapacidad | $_____ | Seguro social/incapacidad | $_____ |
| Pensión alimenticia/niño u adulto | $_____ | Pensión alimenticia/niño u adulto | $_____ |
| Asistencia social | $_____ | Asistencia social | $_____ |
| Otros ingresos | $_____ | 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_____

Fallbrook Union Elementary School District

## 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 |
|---|---|---|---|---|---|
| ☐ 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 |
|---|---|

## Parent/Guardian Information

**Contact #1**

Relationship _____ Full Name _____ Home Phone _____ Work Phone _____

Cell phone _____ Text messages OK? ☐ Yes ☐ No Email _____

Mailing Address: _____

Parent Education Level:
☐ Not a High School Graduate ☐ High School Graduate ☐ Some College
☐ College Graduate ☐ Graduate/Post Grad Training ☐ Decline to state/Unknown

Parent contact allowed:
☐ Contact Allowed ☐ Educational Rights ☐ Has Custody
☐ Lives with ☐ Mailings allowed

Active Military? ☐ Yes ☐ No If yes: Branch _____ Rank: _____
Bldg # _____ Duty Station _____

**Contact #2**

Relationship _____ Full Name _____ Home Phone _____ Work Phone _____

Cell phone _____ Text messages OK? ☐ Yes ☐ No Email _____

Mailing Address: _____

Parent Education Level:
☐ Not a High School Graduate ☐ High School Graduate ☐ Some College
☐ College Graduate ☐ Graduate/Post Grad Training ☐ Decline to state/Unknown

Parent contact allowed:
☐ Contact Allowed ☐ Educational Rights ☐ Has Custody
☐ Lives with ☐ Mailings allowed

Active Military? ☐ Yes ☐ 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 |

*Revised 4/2013*