Fallbrook Union
Elementary School District

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

2022-2023

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 .

2022-2023 Preschool Schedule

Mike Choate Early Childhood Education Center
407 S. Mission Rd.
Fallbrook, CA 92028
(760) 695-9607

AM	PM
Monday – Thursday **8:00 – 11:00 am**	**Monday – Thursday** **12:00 – 3:00 pm**

Class times will be assigned. Eligibility is based on family size and income. Families selected will be assigned a class schedule. If your assigned schedule does not meet your family needs, you may have the option to go on the wait list.

Fallbrook Union Elementary School District

Mike Choate Early Childhood Education 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)

The following applies to **Guardian A**

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

The following applies to **Guardian B**

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:** __________

Previous participation- Have you had a different child previously attend MCC? Yes_____ No_____
If yes, please list name(s); Name ________________ Year _____ Name ________________ Year _____

Family start date: __________ Family ID #__________

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

☐ 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: ____________________

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
- ☐ College Graduate
- ☐ High School Graduate
- ☐ Graduate/Post Grad Training
- ☐ Some College
- ☐ Decline to state/Unknown

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

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
- ☐ College Graduate
- ☐ High School Graduate
- ☐ Graduate/Post Grad Training
- ☐ Some College
- ☐ Decline to state/Unknown

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

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)
- Moving Receipt/Delivery Receipt
- Deed/Escrow papers/Rent Receipt/Property Tax Bill
- Bank Account Checkbook
- Utility Bill/Receipt for Service Start-Up
- District Affidavit Declaration of Residency

Revised 4/2013

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME | SEX | BIRTH DATE

FATHER'S 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* MONTHS | BEGAN TALKING AT* MONTHS | TOILET TRAINING STARTED AT* 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

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

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

Mike Choate Center __________ 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
( )

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: Community Care Licensing

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

   Licensing Office Telephone #: (619) 767-2200

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

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

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

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

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

Mike Choate Center
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

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
Community Care Licensing

ADDRESS
7575 Metropolitan Drive, Suite 110

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Diego, CA	92108	(619)767-2200

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)
Mike Choate Center	407 S. Mission Rd., Fallbrook, CA. 92028

(PRINT THE NAME OF THE CHILD)

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

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

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: ______________

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

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

____________________ (NAME OF CHILD), born ________________ (BIRTH DATE) is being studied for readiness to enter ____________________ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____ 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