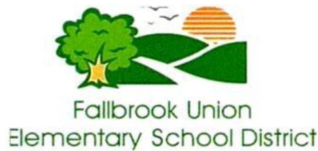


Packet return: Monday-Friday
8:30-10:30 am and 12:30-3:30 pm

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

2023-2024

ENROLLMENT REGISTRATION INFORMATION SHEET
Mike Choate Early Childhood Education Center
(760) 695-9607

You will need:

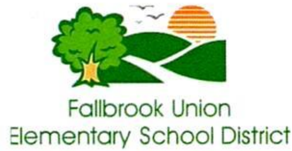
1. **Registered Birth Certificate and Birth Certificate(s) of all dependent children under 18 in the household -** Souvenir birth announcements from the hospital and notification of Registration of Birth are not legal documents.
2. **Current Immunization Record** – Up to date according to state law. 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 .



2023-2024 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

MONIKA HAZEL | 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 included 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.Which Language(s) does your child hear at home? This includes the language(s) spoken by parents, grandparents, siblings, extended family, or others living within or visiting the home.	☐	☐	________
2. Which language(s) does your child hear in their neighborhood and Community? For example, with friends and neighbors, at church, or at after school programs or activities. This is to demonstrate language exposure not to measure language proficiency.	☐	☐	________
3. Which language(s) does your child understand?	☐	☐	________
4. Which languages does your child speak?	☐	☐	________

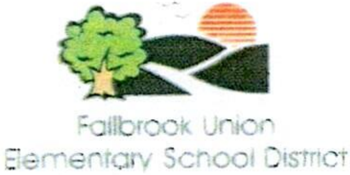
Sources of Income: Please list your average monthly gross income (before deductions)

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: ________**

Diane Sebalj Trustee Area No. 1
Suzanne Lundin Trustee Area No. 2
Ricardo Favela Trustee Area No. 3
Dr. Constance Fish Trustee Area No. 4
Mary McBride Trustee Area No. 5

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 ☐ 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

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

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
(   )

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:

NAME
Community Care Licensing

ADDRESS
3737 Main St STE 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside, CA	92501	(951)782-4200

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

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

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

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
The Mike Choate Early Childhood Center	407 S. Mission Rd Fallbrook CA 92028

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

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

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 3737 Main St STE 700 Riverside CA 92501

   Licensing Office Telephone #: (951) 782-4200

8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (8/08)

(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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee. The Mike Choate Early Childhood Center

Name of Family Child Care Home

Signature (Parent/Authorized Representative) ______________________________ Date______________

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

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

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)

______________________, 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 (HAEMOPHILUS B) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
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

Why Get Health Check-Ups?

Health check-ups are important for all children and youth. Health check-ups are a time to:

- Find and address medical, dental, mental, and behavioral health problems
- Get needed shots
- Ask your doctor questions

Health check-ups can also be used for foster care, sports, camp, or school entry, as needed.

Who is Eligible?

Children and youth up to age 21 who are eligible for Medi-Cal. Children and youth under age 19 with family incomes less than or equal to 200% Federal Income Guidelines are also eligible. Proof of residence and income is not required.

Babies and Toddlers
Birth Through 3 Years

Regular check-ups can keep your baby happy and healthy. You can find out about your baby's growth, weight, and health, and needed shots are given. At 1 year and 2 years, your baby should be tested for lead. A test for anemia is also given. Your child should see a dentist at least once a year starting by age 1.

School Children
4 Through 12 Years

It is important to make sure your child is healthy and ready for school. State laws require children to be up to date on their shots and get a health check-up.

School children will also get vision and hearing screenings. If your child has not had a lead test before, he/she should have one by age 6 or before. Your child should see a dentist at least once a year.

Teens and Young Adults
13 Through 20 Years

Teens need health check-ups too! This is a chance to make sure your teen is growing and developing well. It is also a time for you or your teen to ask the doctor any questions. Extra health check-ups can be given for sports and camp physicals. Your child should see a dentist at least once a year.

Dental

Please contact your local CHDP office for assistance to find a Dentist who accepts Denti-Cal. CHDP may also assist with appointment scheduling and transportation if necessary.

Vision & Hearing

The local CHDP office can provide assistance to obtain vision and hearing services if medically necessary.

Mental Health, Autism and Behavioral Services

Contact the local CHDP office for assistance to access these services.

¿Qué Ofrece el CHDP?

El programa CHDP ayuda a prevenir o encontrar problemas de salud a través de chequeos regulares de salud, sin costo alguno. Un chequeo incluye:

- Historia clínica y del desarrollo
- Examen físico
- Vacunas necesarias
- Examen de la salud bucal y consulta habitual con un dentista empezando a la edad de 1 año
- Evaluación de nutrición
- Evaluación de la conducta
- Examen de la vista
- Pruebas de la audición
- Información de la salud
- Pruebas de laboratorio, que pueden incluir:
  anemia, plomo, tuberculosis, y otros problemas, según sea necesario
- Referencia al programa Especial Suplementario para Mujeres, Bebés, y Niños (WIC) hasta la edad de 5 años

Otros Servicios

Si se necesitan más servicios de la salud, nosotros le ayudaremos encontrar, incluyendo:

- Dentistas que acepten Denti-Cal para el cuidado de la dentadura de su niño
- Especialistas médicos, según sea necesario
- Servicios de salud mental y comportamiento, según sea necesario

El diagnóstico y el tratamiento pueden ser pagados mientras su niño tenga Medi-Cal.

Información

Para obtener más información acerca de CHDP, opciones de transporte o para recibir ayuda para hacer una cita, comuníquese con su oficina local de CHDP.

Información de contacto del condado de Los Angeles:
Los Angeles County
9320 Telstar Ave, Suite 226
El Monte, CA 91731
Teléfono: (800)993-2437
Fax: (626)569-9350

City of Long Beach
2525 Grand Ave.
Long Beach, CA 90815
Teléfono: (562)570-7980
Fax: (562)570-4099

City of Pasadena
1845 North Fair Oaks Ave, Room 2137
Pasadena, CA 91103
Teléfono: (626)744-6015
Fax: (626)396-7324

Para más información, visite el sitio web del Departamento de Servicios para el Cuidado de la Salud de California en:

Chequeos regulares de salud mantienen a su hijo saludable.
Chequeos de salud también pueden encontrar y tartar problemas antes de que se hagan serios.

Edmund G. Brown, Jr.
Governador, Estado de California

PUB 183– LA (Spanish, 9/15)

Español

Programa para la Salud y Prevención de Discapacidades en los Niños y Adolescentes (CHDP)

Chequeos Médicos y Dentales

GRATIS

Para Bebés, Niños y Jóvenes Menores de 21 años de edad con cobertura completa de Medi-Cal o Menores de 19 años de edad con Bajos Ingresos de la Familia.

No se requieren documentos

Parents' Guide to Immunizations

Required for Pre-Kindergarten (Child Care)

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

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

County of San Diego Public Health Centers Immunization Clinic Schedules

Please call to confirm hours and immunization availability.

CENTRAL REGION			
City Heights (619) 229-5400	Central Region Public Health Center* 5202 University Ave., 92105	Monday & Thursday	8:00am – 4:00pm
Southeast City (619) 595-4452	VIP location 3177 A Oceanview Blvd. 92113	Friday	8:00am – 4:00pm
NORTH CENTRAL REGION			
Kearny Mesa (858) 573-7300	North Central Public Health Center 5055 Ruffin Rd., 92123 (Located at the North Central Regional Center)	Monday, Tuesday, Wednesday, Thursday & Friday	8:00am – 4:00pm
SOUTH REGION			
Chula Vista (619) 409-3110	South Region Public Health Center* 690 Oxford St. Suite H, 91911 (Behind Walmart)	Monday, Tuesday, Wednesday, Thursday & Friday	8:00am – 4:00pm
EAST REGION			
El Cajon (619) 441-6500	East Region Public Health Center 367 N. Magnolia Ave., Ste. 101, 92020	Monday, Tuesday, Wednesday, Thursday & Friday	8:00am – 4:00pm
NORTH COASTAL REGIONS			
Fallbrook (760) 967-4401	Fallbrook Community Resource Center 202 W. College Ave., 92028	**The Fallbrook Community Resource Center is temporarily not offering immunizations until further notice. Please call the North Coastal Public Health Center at 760-967-4401 for immunization services.**	
Oceanside (760) 967-4401	North Coastal Public Health Center 3609 Ocean Ranch Bl., Ste. 104, 92056	Monday, Tuesday & Friday	8:00am – 4:00pm
Solana Beach (760) 967-4401	Solana Beach Presbyterian Church 120 Stevens Ave., 92075	**Solana Beach Presbyterian Church is temporarily not offering immunizations until further notice. Please call the North Coastal Public Health Center at 760-967-4401 for immunization services.**	
NORTH INLAND			
Escondido (760) 740-3000	North Inland Public Health Center 649 W. Mission Ave., Suite 2, 92025	Monday, Tuesday, Wednesday, Thursday & Friday	8:00am – 4:00pm
Rancho Peñasquitos (760) 740-3000	New Hope Church 10330 Carmel Mountain Rd., 92129	**New Hope Church is temporarily not offering immunizations until further notice. Please call the North Inland Public Health Center at 760-740-3000 for immunization services.**	
Ramona (760) 740-3000	Ramona Community Resource Center 1521 Main St., 92065	**The Ramona Community Resource Center is temporarily not offering immunizations until further notice. Please call the North Inland Public Health Center at 760-740-3000 for immunization services.**	

*Online appointments available at some locations. Visit: https://onlineappts.hhsa-sdcounty.org/.

For information regarding TB skin testing, please call **(619)692-5565**

For immunization information, please visit our website at www.sandiegocounty.gov/iz.

To find a healthcare provider and other community resources please call **2-1-1 San Diego**.

Updated on 2/24/23