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

2025-2026

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 .

Fallbrook Union
Elementary School District

2025-2026 Preschool Schedule

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

GEN

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

SPED

AM	PM
Monday – Thursday 7:45 – 10:45 am	Monday – Thursday 11:30 – 2:30 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 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**

Family Language and Interest Questions:
Directions: Please answer each of the following questions.

1.What are your child's interests and favorite activities?

2. What are some strengths you see in your child that we can build on?

3. How can we help support your child's language and development at home?

4. Which language(s) does your child speak the most at home?

5. What languages does your child speak with their siblings, grandparents, other family members?

6. Which language(s) does your child speak the most overall?

7. In what language would you prefer to receive written communication from us?

8. In what languages would you prefer us to communicate verbally with you?

Families questions and concerns:

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: _____

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

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

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
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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
( )

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

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)

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:_____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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

FUESD

Consent To Contact Employer
El Consentimiento Para El Contacto Con El Empleador

I give permission for Mike Choate Early Childhood Education Center and its representative to verify all information from my employer to determine my eligibility during the certification process. I understand all information gathered is strictly confidential.

Doy permiso para que Mike Choate Early Childhood Education Center y su representantes verifiquen toda la información de mi empleador para determinar mi elegibilidad durante el proceso de certificación. Yo entiendo que toda la información juntada es estrictamente confidencial.

Employer's Information/*Información del empleador*

Name/Nombre:_____

Address/Dirección:_____

Phone Number/Número de teléfono:_____

Hours of Operation/Horas de operación:_____

Child's Name/Nombre del Niño(a):_____

Parent/Guardian Name/Nombre del Padre/Tutor:_____

Parent/Guardian Signature/Firma del Padre.Tutor:_____

Date/Fecha:_____

Fallbrook Union Elementary School District
Mike Choate Early Childhood Education Center

Family Income Declaration
Declaración de ingresos de la Familia

I,_____ declare other adult involved in the care of _____,
(Parent/Guardian) (Child's name)
who are not reporting an income during the enrollment process, are in fact not receiving any income working at home or through other sources.

I, _____ declare under penalty of perjury that all information stated above is true
(Print name)
and correct.

Signature: _____ Date: _____

Child's Name: _____ DOB: _____

##########

Yo,_____ declaro que otros adultos involucrados en el cuidado de
(Padre/Tutor)
_____,que no están reportando un ingreso durante el proceso de inscripción,
(El nombre del niño)
no reciben ningún ingreso trabajando en casa a través de otras fuentes.

Yo, _____ declaro bajo pena de perjurio que toda la información indicada arriba es
(Imprima su nombre)
verdadera y correcta.

Firma: _____ Fecha: _____

Nombre del Niño:: _____ Fecha de Nacimiento: _____

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

County of San Diego Public Health Centers
Immunization Clinic Schedules

Please call to confirm hours and immunization availability.

CENTRAL REGION			
Southeast (619) 229-5400	Central Public Health Center at Southeastern Live Well Center (SELWC)* 5101 Market St., STE 2000, 92114	Monday, Tuesday, Wednesday, Thursday & Friday Closed: Saturday, Sunday and Holidays	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 Closed: Saturday, Sunday and Holidays	8:00am – 4:00pm
SOUTH REGION			
Chula Vista (619) 409-3110	South Public Health Center* 690 Oxford St. Suite H, 91911 (Behind Walmart)	Monday, Tuesday Wednesday & Friday Thursday Closed: Saturday, Sunday and Holidays	8:00am – 4:00pm 8:00am – 12:00pm
EAST REGION			
El Cajon (619) 441-6500	East Public Health Center 367 N. Magnolia Ave., Ste. 101, 92020	Monday, Tuesday, Wednesday, Thursday & Friday Closed: Saturday, Sunday and Holidays	8:00am – 4:00pm
NORTH COASTAL REGIONS			
Oceanside (760) 967-4401	North Coastal Public Health Center 3609 Ocean Ranch Bl., Ste. 104, 92056	Monday, Tuesday, Thursday & Friday Closed: Saturday, Sunday and Holidays	8:00am – 4:00pm
NORTH INLAND			
Escondido (760) 740-3000	North Inland Public Health Center 649 W. Mission Ave., Suite 2, 92025	Monday, Tuesday, Wednesday, Thursday & Friday Closed: Saturday, Sunday and Holidays	8:00am – 4:00pm
Ramona Community Resources Center (760)-740-3000	1221 Main Street Ramona, CA 92065	1st Tuesday of the month	10:00am – 2:00pm

*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**.