



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

**2026-2027**

## 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.*

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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.*



## 2026-2027 Preschool Schedule

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

### GEN

AM	PM
<b>Monday – Thursday</b> <b>8:00 – 11:00 am</b>	<b>Monday – Thursday</b> <b>12:00 – 3:00 pm</b>

### SPED

AM	PM
<b>Monday – Thursday</b> <b>7:45 – 10:45 am</b>	<b>Monday – Thursday</b> <b>11:30 – 2:30 pm</b>

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:

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

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

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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:

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321 IOWA ST. FALLBROOK, CA 92028 | FUESD.ORG

**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



**Parent/Guardian Information**

**Contact #1**

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

**Contact #2**

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

**Other Children in the Home**

Name <hr/>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB <hr/>	Name <hr/>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB <hr/>
Name <hr/>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB <hr/>	Name <hr/>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB <hr/>

***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

# 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
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**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES	DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps		

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
--	------------------------	---

**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?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? IF YES, WHAT KIND:	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE

DATE



## 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](http://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](http://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

Riverside, CA

ZIP CODE

92501

AREA CODE/TELEPHONE NUMBER

(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)

The Mike Choate Early Childhood Center

(PRINT THE ADDRESS OF THE FACILITY)

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: \_\_\_\_\_



**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: \_\_\_\_\_

Student Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Father's Name/Legal Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Mother's Name/Legal Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**\*MUST CONTACT SCHOOL NURSE – ADDITIONAL FORMS NEEDED FOR SCHOOL.**

MEDICAL HISTORY	YES	NO	NOTES/EXPLANATION
Asthma			Inhaler Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes*
Epilepsy/Seizures			Diastat Prescribed? <input type="checkbox"/> No* <input type="checkbox"/> Yes* Date of Last Seizure: _____
Severe Allergy			EpiPen/Medication Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below) If Yes, When was the EpiPen last used? _____
Food Allergy			EpiPen/Medication Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below) If Yes, When was the EpiPen last used? _____
Seasonal Allergies			Medication Required at school? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below)
Diabetes			Medication Prescribed? <input type="checkbox"/> No* <input type="checkbox"/> Yes* (Please explain Below)
Medication Taken at Home?			Name of Medication: _____
Eye Problems/Glasses			Wears Glasses? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Last Eye Exam: _____
History of Recent or Serious Injury/Operation?			
Digestive Disorder			
Endocrine Disorder			
Hearing Problems			
Speech Disorder			
Urinary/Kidney Problems			
Heart/Blood Condition			
Orthopedic Problems			
Emotional Concerns			
ADD/ADHD			
Other:			

**Known Allergies** (Please describe trigger & allergic reaction): \_\_\_\_\_

**Medications Needed at School\*** (Name, Time, Dose & Reason, Doctor's Note Required): \_\_\_\_\_

**Any P.E. Restrictions?** (Doctor's Note Required): \_\_\_\_\_

**Are there any problems you would like to discuss with the school nurse?**

Physician/Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby certify that the health history of this child is correct to the best of my knowledge and agree to the disclosure of my child's health information between FUESD and external health care professionals.

Signature of Parent/Guardian \_\_\_\_\_ 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) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
HIB MENINGITIS (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

# 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
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## 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
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## 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
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## 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
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## 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
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## 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	1 <sup>st</sup> 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](http://www.sandiegocounty.gov/iz).

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

